Coping and resilience in transgender individuals who have experienced transphobic hostility: an interpretative phenomenological analysis

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Declaration

I declare that this thesis is entirely my own work, other than the counsel of my supervisors, is an accurate reflection of work, and has not been submitted as part of another degree at the University of Limerick or any other academic institution.

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Kristina Cahill Date

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Abstract

Introduction: Trans individuals report experiencing pervasive discrimination, microaggressions, harassment and stigma across their lifespan. Transphobia has been identified as a key contributor to elevated rates of mental health problems and suicidal ideation among trans individuals. The aim of the current study is to gain a deeper understanding of transgender individuals' experiences of transphobic discrimination and hate crime, and how they describe their coping following these experiences, in their own words. This research aims to explore how resilience manifests in trans people with regards to stigma and discrimination.

Method: The researcher interviewed seven trans individuals. Semi-structured interviews were utilized to explore participants' subjective experiences of transphobic discrimination and how they described their coping following these experiences. Interviews were transcribed verbatim.

Findings: An Interpretative Phenomenological Analysis (IPA) approach was employed and revealed a number of superordinate, subordinate, and minor themes in the interview data. The superordinate themes included 'Aftermath of Experiences', 'Coping', and 'Moving Forward'.

Discussion: The research project succeeded in addressing a number of gaps in the transgender discrimination literature; providing greater insight into trans peoples' experiences of discrimination and/or hate crime and how it impacts on their coping and resilience. The results of the study are discussed in relation to the literature, and a number of implications are discussed in the context of clinical practice, education, policy, and future research. Limitations and strengths of the study are also discussed, as well as a critical reflection on the research process.

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GLOSSARY OF TERMS

Terminology within the trans community

There is a wide range of terminology used in the transgender community, and even within the community, there are differences of opinion on the most appropriate terminology to use, as terms can be used interchangeably. The table below is not intended as an all-encompassing glossary of terms, but to act as a general guide for the terms used in the context of this study. It is adapted from the Fenway Institute Glossary of Gender and Transgender terms (Fenway Institute, 2010) and the APA Guidelines for Psychological Practice with Transgender and Gender Nonconforming People (American Psychiatric Association, 2015).

The use of the umbrella term 'transgender' and 'trans' will be used interchangeably throughout this study.

Table 0.1

Definitions of trans terminology used in the context of the current study

Term	Definition
Coming out	A process that involves the trans individual accepting their gender identity and gender expression and choosing to share this information with others.
Female with a trans history	Some individuals will refer to themselves as women of transgender experience, or that they have a trans history. Some people prefer to be referred to as women rather than transwomen or transgender women, as they might not necessarily think of themselves as having transitioned from male to female.
Gender expression	How an individual 'outwardly' presents, this can include their physical appearance and/or behaviours that express a particular gender. Gender expression may or may not correspond with how the individual identifies.

Gender Dysphoria	Refers to the discomfort or distress that is associated with a discrepancy between a person's gender identity and the sex they were assigned at birth. It also refers to the associated gender role and/or primary or secondary sex characteristics Used as the psychiatric term in DSM-5 (American Psychiatric Association, 2013)
Gender identity	Refers to an individual's inherent and deeply rooted identification as male, female, or an alternative gender. This may or may not correspond to the gender they were assigned at birth.
Gender variant	Refers to people whose gender expression is neither masculine nor feminine or different from traditional or stereotypic expectations of how a man or woman should appear or behave. These individuals can engage in behaviours/ interests that are more typical of the "opposite" sex - these are considered gender-variant or gender non-conforming behaviours and interests.
Male with a trans history	Some individuals will refer to themselves as men of transgender experience, or that they have a trans history. Some individuals prefer to be referred to as men rather than transmen or transgender men, and would not necessarily think of themselves as having transitioned from female to male.
Non-binary	Can be an umbrella term for individuals who identify outside the gender binary of either 'male' or 'female'. This can include individuals who identify and present themselves as both, or alternate between male and female. It can also include those who identify with no gender, or a gender outside the male/female binary
Outing or being outed	The disclosure of an individual's hidden gender identity by another without their consent.

Passing or not passing	Passing refers to an individual being perceived as the gender they are presenting in (e.g., based on their dress and mannerisms match according to social norms). Not passing refers to an individual being perceived as their sex assigned at birth, rather than their gender identity.
Transgender	An umbrella term for individuals who identify and/or express in a gender that differs from their birth-assigned gender. Transgender can include individuals at varying levels of transition, those who choose to undergo hormone replacement therapy, and/or gender reassignment surgery, or those who elect/ cannot have either.
Transition	A process through which some trans individuals begin to live their lives as the gender in which they identify. Transitioning can include changing appearance, mannerisms, name, pronouns, and changing legal documents (e.g., birthcert). This can also include medical interventions such as, hormone replacement therapy, electrolysis, feminisation/masculinisation surgery, and gender reassignment surgery. It is important to note that not every trans individual chooses to engage with medical interventions.
Transman	Can be an umbrella term referring to an individual who at birth was assigned the female gender, but who identifies and/or presents as male. This term can be used to apply to men at varying stages of transition. Also known as 'Female-to-Male' (FTM)
Transwoman	Can be an umbrella term referring to an individual who at birth was assigned the male gender, but who identifies and/or presents as female. This term can be used to apply to women at varying stages of transition. Also known as 'Male-to-Female' (MTF)

Defining discrimination, hate crime and hate incidents

Table 0.2

Definitions of various forms of discrimination described in the context of the current study

Term	Definition
Discrimination	Conscious or unconscious behaviour or actions against a person or a group arising from prejudiced attitudes and beliefs. Discriminatory behaviour can include but is not limited to: verbal abuse, graffiti, jokes, slurs and physical assault. Discrimination can include hate crime, but not all acts of discrimination are considered criminal acts, e.g. jokes, taunting, etc. (Hall, 2005)
Hate crime	Any incident, which constitutes a criminal offence, perceived by the victim or any other person, as being motivated by prejudice or hate against an individual's gender identity and/or expression. Hate crime examples can include: public order offences (threatening, abusive or insulting behaviour in public), criminal damage and assault (Blair-Woods & Herman, 2014; Hall, 2005).
Hate incident	The difference between hate crime and hate incident, is that a hate incident may or may not constitute as a criminal offence. Hate incidents examples can include intimidation, use of discriminatory slurs, distribution of prejudicial material, threats of violence etc., (Hall, Corb, Giannasi, & Grieve, 2014).
Micro-aggressions	Refer to the commonplace, active manifestations of derogatory stereotypes that are interpersonally communicated to trans people on a daily basis, and can be presented as verbal, nonverbal or environmental slights, insults or other abasements (Nordmarken, 2014).
Transphobia	Fear, dislike or hatred of people who are trans or are perceived to challenge conventional gender categories or

	'norms' of male/female. Can result in individual & institutional discrimination, prejudice & violence against transgender people (Chrisler & McCreary, 2010).
Secondary victimisation	Refers to subsequent victimisation following on from the original victimisation usually within the context of seeking support from services. The re-traumatisation of the victim through the responses of individuals and institutions is an example of secondary victimisation (Doerner, 2012). Within the context of this study it refers to attitudes and/or behaviours experienced by the trans individual while seeking support from their own support structure, the health system, justice system and other state bodies.
Systemic/ institutional discrimination	Social and organisational structures, including policy and practices, which intentionally or unintentionally exclude, limit and/or discriminate against individuals who are part of the minority group. Some studies have indicated that systemic discrimination may be more insidious because it stems from systems that are impossible to avoid. Furthermore, these systems and institutions share elements of the above-mentioned microaggressions (Nadal, Skolnik, & Wong, 2012)

CHAPTER ONE: INTRODUCTION

1.1 Overview of present study

Contemporary Irish society is not the archaic and insular culture it once was (Smith, 2004). Until 1993, homosexuality in Ireland was illegal and liable for prosecution. Thankfully, Ireland has since made progress in terms of both public attitudes and the rights and legal protections available to the LGBT community; as evidenced most recently by the introduction of the Marriage Act 2015, which legalised same-sex marriage via rational referendum. For the trans community is Ireland, 2015 marked a legislative watershed in the form of the Gender Recognition Act 2015. This Act enables transgender people to achieve full legal recognition of their preferred gender. With the introduction of the GRA, the trans community is now able to achieve full legal recognition of their preferred gender and can now apply for a new birth certificate that reflects this change. The Act also allows all individuals over the age of 18 to self-declare their own gender identity. However, there are limitations to the GRA. The Act does not apply to young trans individuals, intersex persons and non-binary individuals. For the trans individuals the Act does include, being able to apply for a new birth certificate is hugely significant for this community as it allows them to be recognised as their 'true gender' when applying for jobs, a new passport or entry to education. Previously, if the individual had been stated as one gender on some documents and another gender on their birth certificate, there was an increased risk of forced 'outing' of that individual's birth-assigned gender. Forced outing of trans individuals has been linked with harassment, transphobia and potential marginalisation from the community (Beemyn, 2003). However, despite the progress in legal recognition for the trans community, much of the progress made in terms of public acceptance in Ireland concerns sexual orientation (LGB) rather than gender identity (T). There is very little in the literature, with regards to public response to the GRA. As the GRA was introduced without public referendum, it can be seen as positive with respect to State responsibility – in that minorities shouldn't have to ask the majority for their rights, but it means there was no public discussion of trans identities. Trans people are not explicitly named in Irish equality legislation, covering key sites of discrimination such as employment and the provision of goods and services (Schweppe, Haynes, & Carr, 2014). Neither gender, nor gender identity, and

expression are protected categories under legislation addressing hate speech and the country has not introduced legislation to recognise and address hate crime (Haynes & Schweppe, 2016; Schweppe & Walsh, 2008).

Here in Ireland, despite the recent advances in advocacy by/for and inclusivity of the LGBT community, and the recent introduction of gender identity legislation, the trans community remains one of the most marginalised minority groups in Irish society. They experience regular discrimination and harassment because of their gender identity and/or gender expression. Within an Irish context, there had been no systematic research conducted on the prevalence of transphobic discrimination until Transgender Equality Network Ireland (TENI) published their 'Speaking from the Margins' report (McNeil, Bailey, Ellis, & Regan, 2013), a survey on trans mental health and wellbeing; and 'STAD: Stop Transphobia and Discrimination' report (TENI, 2014), documenting transphobic discrimination and hate crime in Ireland. Survey results from the Speaking from the Margins report indicated that 72% of respondents had experienced some form of harassment due to being a transgender person.

In 'Speaking from the Margins', McNeil et al. (2013) reported that the lack of health policy for trans people has led to inconsistent treatment of trans individuals seeking care and treatment. Their results also indicated that there is a significant lack of trans awareness among health professionals at a national level. Their findings also illustrated the limited resources available for psychiatric and psychological supports for trans people. Anecdotal reports indicated that individuals navigate the system without signposts and that there is a lack of a specific designated treatment pathway. Other challenges faced by trans people seeking healthcare include a lack of information on referral pathways for the individual, a lack of understanding of trans health needs on behalf of the health professionals and a dearth of formal education on trans health issues for health care professionals. These findings have been corroborated and supported by subsequent studies based in an Irish context. A number of studies conducted by Edward McCann and colleagues have documented the limited psychiatric and psychological supports resources available for for trans people in Ireland (McCann & Sharek, 2014a; 2014b; McCann 2015). Anecdotal reports indicated that individuals navigate the system without signposts and that there is a

lack of a specific designated treatment pathway. These studies highlighted other challenges faced by trans people in Ireland which includes: a lack of information on referral pathways for trans people seeking healthcare, a lack of understanding of trans health needs on behalf of the health professionals and a dearth of awareness on trans health issues for health care professionals. Currently, there are no specialist support services for trans people in Ireland (McNeil et al, 2013).

Trans individuals report experiencing pervasive discrimination, microaggressions, harassment and stigma across their lifespan (Grant et al., 2010; Lombardi, 2009; Mizock & Lewis, 2008; Clements-Nolle, Guzman, & Harris, 2006). Transphobia has been identified as a key contributor to elevated rates of mental health problems and suicidal ideation among trans individuals (Testa, Habarth, Peta, Balsam, & Bockting, 2015; Bockting, Miner, Swinburne-Romine, Hamilton, & Coleman, 2013; Mizock & Mueser, 2014). The aim of this research is to gain a deeper understanding of how transgender people describe their coping strategies and sources of resilience in the aftermath of experiences of transphobic discrimination and hate crime.

1.2 Research Warrant

There is a dearth of systematic research which examines the psychological and/or emotional effects of transphobic discrimination, and even less so within an Irish context. This study will be unique in that much of the research on the impact of victimisation in this population is criminal in focus rather than psychological. There is scope to conduct research, which can really examine transgender peoples' experiences of discrimination and hostility in their own words. The other significant component to this research is looking at how transgender people cope in the face of this adversity. Within the literature there remains only scant attention given to the coping and resilience resources of these individuals. This research aims to explore where resilience in trans people comes from with regards to stigma and discrimination. This could be invaluable information to feedback to the community. In addition, this study could provide a much-needed learning opportunity for clinicians and health professionals, as it may potentially help to bridge the gap for clinicians in how best to support trans individuals by encouraging and empowering them to draw on both internal and external sources of resilience and coping.

1.3 Theoretical Framework

The current study draws on the minority stress model (Meyer, 2003), and the gender minority stress model (Testa et al., 2015), in order to interpret the participants' descriptions of their experiences of bias motivated hostility and their impacts. In addition, this study draws on the Lazarus and Folkman (1984) model of coping, where problem-focused coping and emotion-focused coping are proposed as responses to stressors. The coping strategies outlined by participants reflect the Lazarus and Folkman (1984) model of coping. However, the findings of the current study extend beyond the Lazarus and Folkman model as participants also describe an appraisal-focus to their coping. As the Lazarus and Folkman model focuses primarily on problem-focused and emotion-focused coping, and this research supports the view that the model is not fully comprehensive and the argument made by authors such as Pearlin & Schooler (1978), Folkman, Lazarus, Gruen & Delongis (1986) and Endler & Parker (1990) that appraisal-focused coping is as valid and significant as problem-focused and emotion-focused coping for alleviating distress. Finally, the study draws on the concepts of post-traumatic growth and resilience (Burnes, Dexter, Richmond, Singh & Cherrington, 2016), in order to interpret how/if participants move forward from their experiences.

1.4 Methodology

Participants were recruited via volunteer sampling through two organisations that work specifically with the LGBTI community. The researcher conducted semi-structured interviews with seven individuals who identified under the umbrella term 'transgender'. Interpretative phenomenological analysis (IPA) (Smith, Flowers, & Larkin, 2013) was chosen as the analytical method for the current study as the research was aimed at exploring the lived experiences of transgender individuals.

1.5 Thesis structure

The thesis is structured as follows: chapter two includes a review of the current literature; chapter three discusses the methodology and data collection procedures for this study; chapter four presents the study's findings in the format of superordinate,

subordinate and minor themes. Finally, chapter five discusses the findings in the context of previous literature and implications of these findings for clinical practice, education, policy, and future research.

CHAPTER TWO: LITERATURE REVIEW

2.1 Chapter introduction

This chapter will firstly conceptualise the trauma associated with discrimination and hostility within the transgender lens. Following this, the psychological effects of discrimination and hate crime will be discussed and how the research has described the coping mechanisms of individuals following these experiences. Coping resources and the resilience of trans people will be explored, with attention given the literature on post-traumatic growth and how this might relate to victims of transphobia. Finally, the rationale for the current study will be described and the research questions will be outlined.

2.2 Literature search

A systematic literature review was conducted which included finding relevant articles by searching several databases. The primary databases used were PsycArticles, SAGE, ScienceDirect and Web of Science. Exclusion criteria included literature on initial gender identity development, as the focus of the study was on experiences of transphobic discrimination, and coping and resilience in the trans individuals who experience transphobia. Key words were used in various combinations to locate articles relating to the subject matter. Key words used in the literature search were: transgender, discrimination, hate crime, psychological resilience, post-traumatic growth, mental health, coping style, coping mechanisms, gender identity, social support, transition.

2.3 On the nature of trans identities

Traditionally, gender has been evaluated on the basis of a binary system of male and female. From a sociological perspective, both sexual orientation and gender identity are based on this constructed two-gender system, reinforcing the binary idea that only the categories male and female exist. In this binary model, sex, gender, and sexuality

have often been assumed to be one and the same (McGeeney & Harvey, 2015). The current binary system, as well as the inclusion of gender identity as part of a psychiatric diagnostic criteria in the DSM, reinforce the idea that there are 'normal' and 'abnormal' ways to express gender, rather than recognize the *"full range of behaviours and experiences engaged in by 'normal' males and females in contemporary society"* (Lev, 2006). Sexual orientation and gender identity both rely on sex/gender categories; they are interconnected in the sense that at the core they are how people identify themselves, yet they differ in that sexual orientation is determined by who an individual is attracted to, while gender identity is based on a person's belief about who they are, and how that might differ from biological characteristics assigned to them at birth (Lombardi, 2009).

2.4 Conceptualising transphobia-related trauma

The life experience of any trans individual is not an easy one. Trans individuals report experiencing pervasive discrimination, microaggressions, harassment and stigma across their lifespan (Grant et al., 2010; Lombardi, 2009; Mizock & Lewis, 2008; Clements-Nolle et al., 2006). Stigma and discrimination have been documented to begin as early as childhood for some trans individuals, with research reporting high incidence of early childhood harassment and invalidation for children who express gender nonconformity (Wallace & Russell, 2013; Grossman, D'Augelli, Howell, & Hubbard, 2005; Cashore & Tuason, 2009). Lombardi (2009) reported that experiences of transphobia and stigma and the stress experienced from the events are related to gender nonconformity at a young age. These experiences have also been linked with the individual coming to terms with their own gender identity and expressing it, as well as the age they were when they transitioned.

Transphobia and transprejudice manifest in negative attitudes and feelings towards transgender people (Chrisler & McCreary, 2010). A study conducted by Stotzer (2008) found that hate crimes toward trans people tend to be more violent in nature in comparison to victims of a non-hate related offence. Stotzer also suggested that that trans people also experience violence and hostility on an intersectional basis, with non-white trans women being at particular risk.

Prevalence rates of transphobic discrimination and experiences of hate crime have been well-documented in recent years. Turner, Whittle, and Combs (2009) complied one of the first quantitative reports of trans people's experiences of hate crime in the EU. They found that 79% of their sample had experienced some form of discrimination ranging from transphobic comments to physical/sexual assault. Their findings also suggested that transgender people were three times more likely to experience a transphobic hate crime or harassment than lesbians or gay men were to experience homophobic hate incidents or crimes. Turner et al. suggested that the link between non-conformity to gender norms and hate crime could potentially account for the increased risk of hate crime in the transgender community. Individuals who do not conform to normative standards of gender, i.e., women who are perceived as masculine, men who are perceived as feminine, or those who do not identify as either gender, are more likely to elicit prejudicial attitudes and beliefs. This has been supported by other research which suggests that perceived gender non-conformity may be at the root of both transphobic and homophobic hate crime (Kosciw, Greytak, Bartkiewicz, Boesen, & Palmer, 2012; Norton & Herek, 2013; Hill & Willoughby, 2005). Transgender individuals can often be judged as well, on how well they 'pass' within society's binary view of gender identity and expression (Lev, 2013). The lack of awareness and recognition of transphobic discrimination is detrimental to this group, as it perpetuates the view that trans people are 'others' rather than legitimate members of our society, further marginalising and isolating them.

In Ireland, the 'STAD: Stop Transphobia and Discrimination' report (TENI, 2014), documented transphobic discrimination and hate crime in Ireland. Survey results from the Speaking from the Margins report indicated that 72% of respondents had experienced some form of harassment due to being a transgender person. The STAD report further explored experiences of transphobic discrimination, and the results indicated harassment varied from verbal threats, property damage to extreme physical violence and rape. The survey found that 78% of respondents reported that their gender identity and gender expression acted as a real or perceived motivation for the incident. Alarmingly, over 50% of respondents did not report their experience of transphobic hate crimes to the police, and the majority of respondents did not seek psychological support from professional services, despite reporting a significant negative psychological impact following the incident. Instead, many individuals

described turning to family, friends or a Trans/LGB NGO for support. This would be in-line with the current literature as hate crimes are generally under-reported worldwide (Clayton, Donovan, & MacDonald, 2016; Dzelme, 2008; Hall, 2005).

Previous literature has also indicated that when transphobic hate crimes occur, trans people can often experience a vicarious traumatisation, or a secondary traumatisation. Secondary traumatisation can occur when the individual seeks support from others, such as family and friends, or from support systems such as, mental health services or law enforcement but instead experience lack of understanding and even blame from those who were supposed to support them (Testa et al., 2012; Dietz, 2001; Berrill & Herek, 1992).

2.4.1 Systemic discrimination

In addition to the stigma and discrimination stemming from members of the public, there is also increasing evidence of trans people experiencing discrimination among individuals or systems who should be offering assistance and support, such as among social and health service providers and law enforcement and justice systems (Stotzer, 2014; Woods, Galvan, Bazargan, Herman, & Chen, 2013; Poteat, German, & Kerrigan, 2013). This has been described as systemic or institutional discrimination. On a global level, research has validated claims that trans people experience regular discrimination while engaging with the justice system. Shannon et al. (2009) found a significant proportion of trans people reported mistreatment by the police officers and this mistreatment was related to their stigmatised identities as trans women. When the individual experiences transphobic discrimination in the justice system, it has been associated with a lack of trust in the system, leading to a decrease in likelihood that the individual will seek help when they need it (Nadal et al., 2012; 2014; Peek, 2003). This is also corroborates with the aforementioned underreporting of harassment and crime in this population. The difference between hate crime and hate incidents could also account for this. Iganski (2008) reported that physical violence constituted a minority of hate crime incidents. Offences tend to range from verbal abuse to harassment, to assaults and criminal damage. Due to the lack of trust in the system

and fear of invalidation and rejection, it is possible that trans people choose not to report their experiences to the police for these very reasons.

A number of studies have documented the barriers to accessing health care for trans people. The relationship between the trans community and health care systems has historically been an uneasy one due to real or perceived stigma originating from the need of formal psychiatric diagnoses such as GID (Drescher, Cohen-Kettenis, & Winter, 2012). Following the difficult process of accessing hormone treatment and other medical interventions, health care professionals are often perceived as 'gate-keepers' in the trans community (Lev, 2013; Cobos & Jones, 2009).

Discrimination while accessing to health care has been conceptualised as a model. Link and Phelan (2006) proposed that discrimination can be experienced through three categories: direct discrimination, structural discrimination and internal discrimination. This is important to consider, especially within the health care setting, as it contextualises the experience of discrimination at many different levels for trans people. There is significant evidence to suggest that trans people have experienced direct and internal discrimination while seeking care in the health system. This has included being rejected for accessing health care on the basis of being trans or making such patients uncomfortable when seeking care (Cruz, 2014). Furthermore, when people do access services, they can experience delays and barriers, such as prejudice on the part of some health care providers, which causes unnecessary hardship (Jalali & Sauer, 2015; Roberts & Fantz, 2014) In Ireland, trans people seeking health care still face unpredictable and sometimes negative responses from practitioners (Mayock, Bryan, Carr, & Kitching, 2009).

An example of structural discrimination could be the lack of service providers equipped to serve trans people. In 'Speaking from the Margins', McNeil et al. (2013) reported that the lack of health policy for trans people has led to inconsistent treatment of trans individuals seeking care and treatment. Their results also indicated that there is a significant lack of trans awareness among health professionals at a national level. Their findings also illustrated the limited resources available for psychiatric and psychological supports for trans people. Anecdotal reports indicated that individuals navigate the system without signposts and that there is a lack of a specific designated treatment pathway. Other challenges faced by trans people

seeking healthcare include a lack of information on referral pathways for the individual, a lack of understanding of trans health needs on behalf of the health professionals and a dearth of formal training on trans health issues for health care professionals. Health care professionals, such as clinical psychologists, or community health nurses, in the general mental health services, are given brief training around gender identity during their professional training but more often than not, this information is generalised to the LGBT community, and does not include specialist knowledge on trans peoples' wellbeing (McCann & Sharek, 2014a; 2014b).

2.4.2 Employment discrimination

Research has also shown that trans individuals face significant challenges when it comes to employment opportunities and maintaining employment (Nadal, Davidoff, & Fujii-Doe, 2014; Fassinger, 2007). In their qualitative study, Budge, Tebbe, and Howard (2010) explored occupational barriers and workplace discrimination among trans individuals. Participants reported experiences with direct discrimination, job losses, difficulty gaining employment, gendered bathroom discrimination, and gender stereotypes in the workplace.

Discrimination in the workplace can take many forms for trans people. Following the often-difficult process of gaining employment, trans people can be subject to many direct and indirect forms of discrimination within the workplace, such as employer or co-worker fears and misperceptions, hostility, isolation, lack of collaboration, transphobic language, inappropriate questioning, harassment, as well as placing conditions on their employment (Budge et al., 2010; O'Neil, McWhirter, & Cerezo, 2008). All of these barriers make it extremely difficult for trans people to maintain a job. As there are inconsistencies across workplace policies protecting against discrimination of trans people, acquiring meaningful employment is made increasingly difficult for the trans community. Some researchers posited that individuals who begin transition processes while maintaining the same job face even greater challenges than those who have already transitioned to their preferred gender (Budge et al., 2010; Schilt & Connell, 2007).

A report published by the National Centre for Transgender Equality and the National Gay and Lesbian Task Force (Grant et al., 2010) looked at experiences of transphobic discrimination across the United States. With regards to employment, the number of unemployed trans participants was twice that of the national average of unemployed people. Within their sample, nearly half (47%) of respondents reported negative experiences with regards to gaining employment, maintaining employment and advancing in their career. A staggering 97% of respondents reported experiencing harassment, such as verbal abuse, or mistreatment, such as being deliberately misgendered, within the workplace.

Discrimination in the workplace on the basis of gender identity has been well-documented and evidenced by other researchers. Trans individuals face significant barriers in employment such as being fired, demoted, or unfairly disciplined. Whether explicitly stated or implied, it is generally agreed that discrimination against gender identity is part of the motivation behind trans peoples' unfair treatment in the workplace (Mizock & Mueser, 2014; Mizock & Fleming, 2011; Vance et al., 2010; Badgett, Lau, Sears, & Ho, 2007). In an Irish context, Mayock et al. (2009) found a significant proportion (26.8%) of respondents in their survey reported having been called abusive names relating to their gender identity within the workplace. Other experiences reported included verbal threats, being physically threatened, and missing work for fear of experiencing the above. While overt forms of harassment within the workplace were generally low, respondents reported feeling frustrated at current workplace policies which they felt reinforced their marginalised status. There were also the implications for long-term unemployment to consider, such as dependence on the State and consequent poverty.

2.5 Understanding the effect of transphobic discrimination on the individual

How experiences of hate crime and discrimination affects minority groups has been examined extensively in recent years. Iganski (2008) reported that the effects of hate crime inflicts greater harm on the victim than victims of non-hate related crimes and can have an increased detrimental impact on the victim due the personal nature of the crime. There is also a significant emotional impact of victimisation from hate crime that differs from victimisation of non-hate parallel offences. Victims of transphobic

hate crime are targeted as a result of hostility or prejudice towards that person's social identity or fundamental characteristics i.e. gender identity. There is an increased risk of repeat victimisation as the targeted characteristics are those they cannot change about themselves. Therefore victims of hate crime can often feel powerless in the face of repeat discrimination and that there is little they can do to manage or prevent the risk of future victimisation (FRA, 2012). The All Wales Hate Crime Research Project conducted by Cardiff University found that among all victims of hate crime, transgender people suffered the most severely and were at the highest risk for suicidal ideation in comparison to other victims of hate crime (Williams & Tregidga, 2014). Waters and Paterson (2015) examined the effects of transphobic hate crime on emotions and behaviours of transgender people. Their findings reflected those of the All Wales Hate Crime Research Project, whereby they found that transgender people reported feeling more threatened, vulnerable and anxious in comparison to other victims of hate crime.

In addition, the impact of hate crime is not limited to simply the victim; it also influences the perceptions of safety for other members of the victim's minority group (Walters & Paterson, 2015). A way of conceptualising the distress caused by repeated incidents of discrimination is through the minority stress model.

2.5.1 Minority stress

The minority stress model has been used to explain the increased risk for psychological distress and coping behaviours amongst the LGB community (Meyer, 2003). The model proposes that members of the LGB community, like members of any minority group, are subject to chronic psychological stress due to their group's experiences of stigmatisation and discrimination in society. Numerous studies have shown that within the LGBT community, individuals experience an elevated degree of prejudice, which in turn elicits stress responses, such as anxiety. With increased risk of repeat victimisations, the cumulative effect of stress over time leads to poor physical health, and also coalesces in disproportionately high rates of psychological distress (Testa et al., 2012; Pascoe & Richman, 2009; Meyer & Northridge, 2007; Meyer, 2003). This type of stress is unique to marginalised and stigmatised

populations (Meyer, 2003) and stems from the conflict between an individual's self-identity and the expectations of the social, cultural, and political environments around them.

Testa and colleagues (2015) built upon Meyer's minority stress model, with one specific to the experiences faced by trans individuals. The gender minority stress model provides a conceptual framework for understanding the negative impact of discrimination and hate crime on the health and wellbeing of the trans community. It describes how different external and internal stressors specific to trans identity, as well as resilience factors, impact on mental health in trans people. Testa et al. hypothesised that four external stressors: gender-based victimisation, gender-based rejection, gender-based discrimination, and identity non-affirmation, can lead to three types of internal stressors: negative expectations for future events, internalised transphobia, and fear of disclosing one's identity. The model proposes that trans individuals are exposed to prejudice and harassment, and these external stressors are related to symptoms of psychological distress, including suicidal ideation, anxiety, and depression. The model also emphasises that trans individuals may internalise society's negative beliefs and assumptions about trans people into their self-concept- in what is referred to as internalised transphobia. Internalised transphobia has been associated with negative self-appraisals (Williams & Tregidga, 2014; Testa et al., 2012; Morrow, 2004). Finally, the model proposes experiences of transphobic discrimination may promote stigma hypervigilance or increased fear of encountering future discrimination. Thus, for transgender individuals, the often daily onslaught of transphobic microaggressions and discrimination, as well as the increased risk of hate incident victimisation leads to pervasive experiences of minority stress that may contribute to the development of psychological distress.

2.5.2 Mental health

The relationship between transphobic discrimination and the prevalence of mental health difficulties has been well-documented in the current literature (Hughto, Reisner, & Pachankis, 2015; Reisner, Bailey, & Sevelius, 2014; Budge, Adelson, & Howard, 2013; Bazargan & Galvan, 2012). As mentioned previously, research have shown that those who experience hate crimes report a wider range of negative

psychological impacts which have a longer durability than those exhibited by victims of non-hate parallel offences (FRA, 2012; Iganski, 2008). The psychological sequelae of hate crime can manifest as: fear, depression, suicidal ideation, anxiety and panic, substance misuse, feeling powerless and helpless, and hypervigilance around repeat victimisation (Herek et al., 1999; 1997; Barnes & Ephross, 1994; Keuroghlian, Reisner, White, & Weiss, 2015). Within the LGB community, hate crime victimisation has been found to increase fear of repeat victimisation, greater perceived vulnerability, decreased trust in the benevolence of others and a lower sense of autonomy (Szymanski, 2005; Herek et al., 1999).

Transphobia has been identified as a key contributor in relation to elevated rates of mental health problems and suicidal ideation among trans individuals (Testa et al., 2015; Bockting et al., 2013; Mizock & Mueser, 2014). Suicidal ideation in particular, has been noted as a significant issue in trans samples. Nuttbrock et al. (2010) reported significantly high rates of psychological distress within their sample as a result of transphobia. They found that suicidal ideation (53.5%) was more than three times higher than the corresponding National Comorbidity Survey estimate in the general population (13.5%). They also found that chronic depression (54.3%) was almost three times higher in trans people who had experienced transphobia. Their results mirror those found in similar studies where rates of attempted suicide are also alarmingly high, with research indicating that between 18% and 54% of trans people attempt suicide (McCann & Sharek, 2016; Moody & Smith, 2013; House, Van Horn, Coppeans, & Stepleman, 2011; Grant et al., 2010; Clements-Nolle et al., 2006; Kenagy, 2005; Dean et al., 2000). Suicide risk is particularly high among transgender individuals who had been victimised, harassed and rejected (Grant et al., 2010; Nuttbrock et al., 2010; Grossman & D'Augelli, 2007). In the Irish study, Supporting LGBT Lives, 80% of trans respondents reported having seriously thought about ending their lives; 26% reported that they had attempted suicide at least once (Mayock et al., 2009; Bryan & Mayock, 2012; Haas, Rodgers, & Herman, 2014).

Studies have linked the increased risk for stress, isolation, anxiety, depression, poor self-esteem in trans individuals with minority stress (Breslow et al., 2015; Hoffman, 2014; Gamarel, Reisner, Laurenceau, Nemoto, & Operario, 2014). Mizock and Mueser (2014) examined how stigma towards trans individuals impacted on their wellbeing. They found that elevated levels of stigma, both internalised and

externalised, were associated with elevated symptoms of depression, anxiety and suicidal thoughts. There is also evidence that transphobic stigma and discrimination is linked to feelings of shame and powerlessness (Spicer, 2010). Minority stress has been associated with poor physical health outcomes in addition to mental health difficulties (Reisner et al., 2014; Sugano, Nemoto, & Operario, 2006).

2.6 Coping following experiences of violence and discrimination

The behavioural and personal implications, and consequences of hate crime and discrimination, for the individual and the community are far-reaching and extensive. Sense of safety and security, and concern and uncertainty about the future are all impacted. Dzelme (2008) discussed the personal implications of hate crime for various minority groups at an individual and at a social level. Personal implications for victims of hate crime can include various physical and psychological constrictions, such as: the person making deliberate changes to their appearance and behaviours to avoid being singled out. In attempts to avoid repeat victimisation, the individual will try to build a safety barrier around them. They become mistrustful of others, apprehensive and hypervigilant in their immediate surroundings, and taking serious precautions, such as restricting themselves to certain places or activities. This also impacts on their self-confidence, as they feel less autonomous. The individual consequences also overlap with the social implications. These can include: the person withdrawing and deliberate isolating themselves for fear of repeat attack, feeling resentment and increased anger towards others, strain on personal relationships as the individual is less trusting, leading to a decrease in social support, and finally, moving location to avoid future attack, such as moving house, or even moving country. The individual and social implications model outlined by Dzelme (2008) is in congruence with findings of other studies on the impact of hate crime on emotion and behaviour (Joseph & Kuo, 2009; Pachankis, 2007). Waters and Paterson (2015) reported on the impact of hate crime on trans people and found some coping responses included engaging in pro-action behaviours (e.g., join LGBT advocacy and support groups), not wanting to seek (violent) retaliation, engaging in avoidant behaviours, such as seeing friends less often and changing their appearance. The authors reported that this intention to avoid was a consequence of hate crime victimisation.

Similarly, in their study which examined the impact of hate violence on a specific minority group who experienced lifelong discrimination, Barnes and Ephross (1994) found one-third of their sample (33.9 percent) reported behavioural changes as both coping responses to their experiences and as attempts to avoid potential future victimization. These behavioural changes included moving out of their home, decreasing social participation, investing in methods of self-protection to avoid potential future victimisation, and increasing safety precautions. Barnes and Ephross conceptualised the behavioural responses of victims into avoidant and active coping. Moving house or location, represented avoidant coping mechanisms that some victims adopted. In contrast to avoidant coping, active coping involved the victims adopting an active stance in order to prevent future victimisation preparations, such as the investing in methods of self-protection.

Coping in the aftermath of traumatic experiences such as hate crime victimisation or protracted experiences of discrimination is a critical psychological process to consider. The concept of coping has amassed extensive attention within the literature due to its role in managing stress and psychological well-being. For the purposes of this study, a person's coping refers to the cognitive, emotional and behavioural processes aimed at reducing psychological distress or a perceived threat (Prati & Pietrantoni, 2009; Zeidner & Endler, 1996; Lazarus & Folkman, 1984). While there are a large number of different models of coping, the most notable is Lazarus and Folkman's (1984) multidimensional model where coping can be conceptualised as problem-focused and emotion-focused coping. This model has formed the basis of subsequent conceptualisations of coping in response to stressors (Zaumseil & Schwarz, 2014).

Problem-focused coping is aimed at reducing the stress associated with a situation or event and involves an effort by an individual to mobilise various factors in order to target the source of the stress (Carroll, 2013; Joseph & Kuo, 2009). Problem-focused strategies may be directed at either the environment (e.g., seeking information or help in managing the situation, or taking control in a situation where possible, planning, altering or removing the source of the stress, removing oneself from the stressful situation), or the self (e.g., problem solving, reappraisal of the meaning derived from

an event, recognising personal strengths and self-acceptance) (Weiten & Lloyd, 2008; Lazarus & Folkman, 1984).

Problem-focused coping differs then from emotion-focused coping, which is aimed at managing the emotions that arise as a response to a situation. Emotion-focused strategies are aimed at regulating one's emotional responses without changing or eliminating the source of the stress. These strategies can include, but are not limited to: distancing, avoiding, selective attention, blaming, minimising, wishful thinking, venting emotions, seeking social support, exercising, and acceptance (self-acceptance, or acceptance of situation) and positive reappraisal (Carver & Vargas, 2011; Ben-Zur, 2009; Folkman & Lazarus, 1988). The focus of these strategies is to change the emotion derived from the stress or focus attention away from it. Emotion-focused coping has been described as better suited for stressors that are perceived to be beyond the control of the individual (e.g., victims of hate crime (Ahluwalia & Pellettiere, 2010) or people who are routinely stigmatised because of their identity (Miller & Kaiser, 2001)).

Looking at implications of discrimination and coping within the trans community, research has indicated that trans people engage in a variety of coping mechanisms at a behavioural, emotional and cognitive levels, not unlike the literature outlined above. Due to fear of future victimisation, studies have found that transgender people can change or conceal their self-presentation and appearance for different social purposes, such as self-protection, or to promote passing (Bockting et al., 2013; Cashore & Tuason, 2009; Levitt & Hiestand, 2004). Even though preoccupation with passing in society is aimed at reducing psychological distress and anxiety of victimisation, it can actually contribute to hypervigilance, and in turn increase levels of stress and anxiety (Bockting et al., 2013). Similarly, Waters and Paterson (2015) found that trans people were more likely to engage in avoidant (i.e., not going out as much) and conformity behaviours (i.e., changing their appearance) in order to avoid experiences of transphobic discrimination. In a grounded theory study conducted by Van Wagenen, Driskell, and Bradford (2013), although the primary focus of the study explored successful aging in LGBT older adults, the themes that emerged indicated that some participants engaged in mechanisms such as reappraisal, acceptance, advocacy and

self-affirmation in response to their experiences of lifelong adversity and stigmatisation and found this beneficial in coming to terms with their experiences.

2.6.1 Social support

In addition to internal coping mechanisms to manage experiences of stigmatisation and discrimination, many individuals will seek external social support. Individuals can seek informal (e.g., family, friends and peers (Doty, Willoughby, Lindahl, & Malik, 2010; Mizock & Lewis, 2008; Jasinskaja-Lahti, Liebkind, Jaakkola, & Reuter, 2006)) and formal support (e.g., health professionals, the justice system, or community support groups (McCann, 2015; Berrill & Herek, 1990)). Studies have found that engagement with other trans people and linking with community supports significantly influences resilience during gender identity development and transition, as it has been associated with feeling less alone, reduced fear and anxiety and less suicidality (Hughto et al., 2015; Testa et al., 2014; Mizock & Lewis, 2008). Social support and community involvement and advocacy have been shown to alleviate the symptoms of psychological distress associated with stigmatisation (Bockting et al., 2013). The importance of community support groups and social support for managing the effects of stigma has been stressed in the literature, as imperative emotional support (Trujillo et al., 2017; Bradford et al., 2013; Schrock et al., 2004). In their qualitative study on the lived experiences of transphobic discrimination, Singh, Hays, and Watson (2011) highlighted that a connection with a supportive community and social support contributed to their participants' well-being and was a significant aspect of their resilience and coping. Participants felt that connection with social supports helped encourage them they felt overwhelmed and less resilient to challenges.

2.7 Psychological resilience in transgender individuals

The concept of psychological resilience is one that generates a lot of debate within the literature. One of the primary difficulties in is there is a distinct lack of consensus with respect to the manner in which resilience is defined and conceptualised.

Although there is no universally agreed definition, it has been routinely defined as a trait, process or outcome. For example, Jew, Green, and Kroger (1999), conceptualised resilience as a set of learned behaviours evolving from an individual's internal working model that influences their ability to cope. Conversely, Harvey (2007) conceptualised resilience as the resources an individual has available to be able to deal with stressful situations.

Despite the lack of consensus regarding a clear definition, the majority of researchers concur that resilience is based around two core concepts: the overcoming of adversity and positive adaptation following adversity (McCleary & Figley, 2017; Fletcher & Sarkar, 2013; Lepore & Revenson, 2006; Fergus & Zimmerman, 2005). For the purpose of the present study, psychological resilience will be defined as the ability to and process of overcoming factors that increase the risk of psychological distress and positive adaptation in the aftermath of a potentially traumatic event. Resilience, in the context of this study, is considered as a process, rather than a trait. In line with Rutter (2012), the process of resilience for each individual is a completely unique and personal experience.

Although exposure to traumatic events was traditionally considered to detract from an individual's ability to cope, recent literature has suggested that people with a history of some lifetime adversity reported better mental health outcomes and more positive and adaptive coping mechanisms than people with no history of adversity (Seery, Holman, & Silver, 2010; Shrira, Palgi, Ben-Ezra, & Shmotkin, 2010). It has even been suggested that exposure to adversity in moderation can actually promote resilience, as it has the potential to mobilise the individual into tapping into previously unfamiliar resources, help them engage social support networks, and create a sense of adaptability for future adversities (McCleary & Figley, 2017).

These positive life changes following adversity have been referred to by some researchers as post-traumatic growth, and a potential outcome of coping with traumatic life experiences (Dekel, Mandl, & Soloman, 2011; Tedeschi & Calhoun, 1996; 2004). Post-traumatic growth has been described as the process of taking some meaning from the event and incorporating it into one's self-concept, such as, reflecting on positive outcomes from negative events and identifying some, or any, therapeutic features of the experience (Park & Ai, 2006; Park & Fenster, 2004).

Tedeschi and Calhoun (1996) reported that an individual can experience post-traumatic growth in a number of different ways including: a greater appreciation of life and prioritising more positive, life-affirming goals; warmer, more supportive relationships with others; a greater sense of inner strength; exploring the possibility of new avenues or pathways for one's life; and spiritual development. Other researchers expanded on this and have described post-traumatic growth following a traumatic event or a series of events, as positive changes which may be profound (e.g., greater advocacy awareness, increased confidence, independence, and self-efficacy (Burt & Katz, 1987), psychological preparedness for future adversity (Janoff-Bulman, 2004), and increased self-understanding and self-acceptance (Ruini & Vescovelli, 2013; Joseph, Murphy, & Regel, 2012; Armeli, Gunthert, & Cohen, 2001)). Or growth may involve smaller changes such as improving relationships and dealing better with stress (Park & Fenster, 2004); improved cognitive and behavioural coping skills and increased personal and social resources such as increased self-reliance (Cadell, Regehr, & Hemsworth, 2003; Schaefer & Moos, 1998). However, this link between experiences of adversity and post-traumatic growth has not been made explicitly within the trans community, therefore it might be difficult to generalise the above findings within a community who face stigmatisation on a continuous and pervasive level.

Although, there is a dearth of research regarding post-traumatic growth in the trans community, recent years have seen an increase in the research on the resiliency of this population. Within the context of the trans community, it is important to note that they are not a homogenous group. Within this population is a diverse range of perspectives, experiences, identities and expression of gender (Austin & Craig, 2015). However amidst the diversity in this minority group, a binding trait that links each member of this community is the resiliency displayed by a population who undergo significant levels of marginalisation and stigmatisation (Singh, 2013; Singh et al., 2011; Singh & McKleroy, 2011).

Riggle, Rotosky, McCants, and Pascale-Hague (2011) conducted a qualitative study exploring the positive aspects of transgender self-identity. Their findings provided a greater understanding about participants' perceptions of internal strengths and resources gained as a result of being transgender. This study focused on how trans people generate meaning from their experiences, and the process by which they

understand their identity as a trans person. Their findings revealed eight positive identity themes: congruency of self; enhanced interpersonal relationships; personal growth and resiliency; increased empathy; increased activism; and a greater connection to the LGBT communities. These findings gave a greater understanding of the aspects of navigating a trans identity that result in resilience and self-acceptance. The implications from these findings highlighted that the frequent adversity and hardship that is associated with being trans in a society that is often non-inclusive, can lead to increased self-awareness, internal strength, and courage to stand up for oneself. Similarly, Austin (2016) reported a similar process within a sample of trans people. Participants described facing adverse experiences such as frequent stigmatisation and how it challenged their process of moving toward self-acceptance. Austin reported that although the process toward self-acceptance was not an easy one for participants, nevertheless it was a gradual, unremitting process.

Looking at the lived experiences of trans people, Singh et al. (2011) conducted a qualitative study exploring the resiliency transgender people have developed in response to societal stigma and discrimination. Their phenomenological inquiry identified a number of unique aspects of resiliency among diverse samples of trans individuals including: evolving a self-generated definition of self and using their own words and terms to define gender; embracing their own self-worth; and a connection with a supportive community all helped with coping in the face of discrimination. Participants also reported the importance of cultivating hope for the future as helpful for encouraging them when they felt overwhelmed by challenges.

Similarly, Singh and McKleroy (2011) conducted a phenomenological inquiry into the resilience of trans people of colour and found comparable themes with the findings of Singh et al. (2011). Key components of their resilience to traumatic life events involved having a strong sense of pride in their gender identities, recognising and negotiating gender oppression, navigating relationships with family, being able to access supportive health care and financial resources, connecting with an activist trans community, and finally, cultivating spirituality and hope for the future.

Mizock and Mueser (2014) also explored how transgender people dealt with these experiences of transphobia. They identified a number of different categories of strategies, coping at an individual, interpersonal and systemic level. At an individual

level, participants reported using gender conformity, self-affirmation, emotional regulation and cognitive reframing as coping mechanisms to deal with transphobia. Interpersonally, participants reported being able to access relational supports and engaging interpersonally with others, as well as using a preventative-preparative approach to cope with transphobia. Finally, at a systemic level, participants described being able to access various services, connecting with their spirituality and engaging in activism and advocacy as effective coping strategies when dealing with transphobia.

The findings of Singh et al. (2011), Singh and McKleroy (2011) and Mizock and Mueser (2014), all identified that resilience in response to transphobia, was not just comprised of internal learned behaviours, but resilience also involved being able to connect to a wider community that in turn reflected to them their strengths when they could not do so for themselves. The importance of community and connection for transgender people has been well-documented as a significant positive factor contributing to their wellbeing (Lev, 2007). Although the concept of post-traumatic growth following experiences of transphobia is not explicitly stated in these studies, the themes highlighted above mirror similar findings in different populations. Increased self-efficacy and autonomy, taking pride in one's gender identity and having a greater sense of self could be compared with greater self-efficacy and self-understanding found in LGB individuals who have had difficult experiences of coming out (Cox, Dewaele, Van Houtte, & Vincke, 2010); other minority groups experiencing racism and oppression (Hall et al., 2010); and assault survivors who have endured significant trauma (Kleim & Ehlers, 2009).

2.8 The current study

Findings from the STAD report indicated a significant psychological impact on those who reported experiences of discrimination and transphobic crime (McNeil et al., 2013). Research has shown that discrimination and victimisation are related to several measures of psychological distress such as anxiety, depression and suicidal ideation in this community (Clements-Nolle et al., 2008). However, there is a dearth of systematic research which examines the psychological and/or emotional effects of transphobic discrimination, and even less so within an Irish context. This study will

be unique in that much of the research on the impact of victimisation in this population is criminal in focus rather than psychological. There is scope to conduct research which can really examine transgender peoples' experiences of discrimination and hostility in their own words. The other significant component to this research is looking at how transgender people cope in the face of this adversity. Within the literature there remains only scant attention given to the coping and resilience resources of these individuals. This research aims to explore where resilience in trans people comes from with regards to stigma and discrimination. This could be invaluable information to feedback to the community.

This study also provides a much-needed learning opportunity for clinicians and health professionals. Results from the STAD report indicated that the majority of respondents who experienced varying degrees of discrimination and victimisation did not seek psychological support from professional services. Given the significant psychological distress experienced by these individuals, there is clearly a barrier for these people in being able to access appropriate services. This study has the potential to act as a sounding board to improve how health services in Ireland advocate and support trans individuals. Also, as a minority population, clinicians are less likely to come into contact with transgender clients as part of their clinical practice. Although visibility of trans people is increasing and more clients who identify as trans are seeking therapy services, there are limited resources available to clinicians, as well as gaps in the literature regarding trans peoples' experiences with mental health. This study could potentially help to bridge the gap for clinicians in how best to support trans individuals by encouraging and empowering them to draw on both internal and external sources of resilience and coping.

2.9 Research questions

This study has constructed three broad research questions to allow for unanticipated themes to emerge from the data. These questions include:

- How do transgender people describe the meaning of their lived experiences of transphobic discrimination?

- How do transgender people describe their coping or resilience strategies in response to these experiences?
- How do transgender people describe accessing support systems, be they internal or external (i.e., family, friends, community services etc.) following these experiences?

CHAPTER THREE: METHODOLOGY

3.1 Chapter introduction

This chapter outlines the empirical strategy of this study and the rationale for the approach chosen. The philosophical underpinnings of the analytical process will also be described. Information on sampling and the data collection procedure will also be provided. The conclusion of this chapter will discuss the ethical considerations of this study, quality considerations in qualitative research, and the reflective process of this research.

3.2 Rationale for methodology

The aim of the current study was to gain insight into lived experiences, specifically trans individuals' experiences of transphobic discrimination and hate crime and their coping following these experiences. As the focus for exploration centred on how these individuals interpret their experiences, a qualitative approach was deemed most appropriate. Qualitative research explores how individuals make sense of their world from their own point of view and how their beliefs contribute to identity formation. At a very basic level, the theoretical underpinning of qualitative research is the 'humanistic' approach; the aim of which is to achieve a greater and more in-depth understanding of our social world by drawing on the individual's underlying processes, perspectives and interpretations (Alasuutari, 2010; Pietkiewicz & Smith, 2014). Although qualitative methodologies allow the researcher to conceptualise specific phenomena in the larger sense, the most important feature is it also allows for consideration of individual differences and variations. The data that is then collected in qualitative research is a product of the interaction between the researcher and participant (Polkinghorne, 2005).

Quantitative research relies on the deductive method of reasoning where pre-constructed theories are tested and inferences made from the data obtained can be applied from the sample to the population (Laurie, 1992). Quantitative data also

implies that the information gathered is a direct representation of what is being measured and is completely independent of the researcher (Polkinghorne, 2005). The quantitative approach takes a primarily positivist stance, whereby the only reliable and verifiable data or evidence to support a theory, is that which is initially collected via people's sensory experiences, and then examined through numerical values (Bryman, 1988). The focus of quantitative research is not necessarily concerned with the participant's perceptions of an event, for example, but instead with an objective representation of that event. In these circumstances, the researcher takes an outsider role as viewing the social world from an objective perspective - the 'detached scientific observer' (Bryman, 1988). Although a quantitative approach can provide a more definitive response to testing causal relationships between variables, it would not have allowed for a full exploration of how these individuals interpret their experiences.

3.3 Interpretative phenomenological analysis (IPA)

Interpretative phenomenological analysis (IPA) (Smith, Flowers, & Larkin, 2013) was chosen as the analytical method for the current study for a number of reasons. Firstly, a significant deciding factor was the focus of the research on the lived experiences of transgender individuals. In addition, the researcher was more interested in examining how transgender individuals interpreted their experiences and how they attributed meaning to them, which suggested a more phenomenological approach. This approach is valuable due to its capacity for providing flexibility to the researcher to gain different individual insights (Pietkiewicz & Smith, 2012), as well as involving a detailed exploration of the participant's experiences. This approach attempts to explore personal experience through the perception of the individual, as opposed to an attempt to produce an objective statement of the object or event itself (Smith & Osborn, 2003).

IPA draws from idiographic, phenomenological, and hermeneutic philosophical approaches to viewing the social world, which rejects the conventional scientific method and places great importance on the individual's interpretation of the world around them (Pietkiewicz & Smith, 2012; Eatough & Smith, 2006; Smith & Osborn, 2003).

The idiographic influence within IPA refers to the attention to what is particular and unique about the individual. It differs from traditional nomothetic approach, as the focus centres on the interaction of different factors, which are specific and unique to each individual (Bryman, 1988; Smith, 2003). The idiographic approach proposes that people can offer unique perspectives on their own experience of a phenomenon (Smith et al., 2013). A critical component to the idiographic influence is the case-by-case analysis process that occurs prior to any attempt at discussing transferability (Smith et al., 2013). One of the benefits of this is that it affords the researcher flexibility in being able to discuss general statement about the data collectively, but also quickly retrieve information at an individual level.

Phenomenology is a philosophical approach to studying experience in the manner it occurs (Smith et al., 2013). The core concept of phenomenology is to consider the world lived by the individual and how the individual interprets their world, rather than viewing them as separate entities (Reid, Flowers, & Larkin, 2005). In phenomenology, emphasis is placed on the subjective rather than objective accounts and the view of individuals is that rather than impassively viewing the world around them as an objective experience, they are actively trying to find their own meaning and significance in their world by formulating their own interpretations (Brocki & Wearden, 2006). This is an important process in order to understand the subjective experience of the individual. The key components of IPA are primarily concerned with meaning, in the sense that it aims to comprehend and appreciate how people make sense of their world and the world around them through their experiences of particular events or situations. Therefore, it focuses on the individual's self-examination and perception of an event on a subjective level (Willig, 2001; Smith & Osborn, 2003).

Hermeneutics serves as a framework for the theory of interpretation. Within this sphere, equal importance is placed on the roles of both the researcher and the participant. This is significant, as in order to fully understand and interpret the meaning behind the participant's account; the researcher must play an active role in the entire process. They form a familiar relationship with the participant, due to the sustained contact involved and also because it aids the researcher to grasp the participant's point of view, gaining an insider perspective and thereby allowing them to subjectively interpret the participant's account. This is referred to as the

'hermeneutic circle' (Smith & Osborn, 2003). The process of interpretation involves concentrating on the details that may seem trivial or inconsequential within an experience with the aim of understanding the meaning behind those details (Laverty, 2003).

Another important concept to reference within IPA is the double hermeneutic (Smith & Osborn, 2003; Smith et al., 2013) - where the participant aims to convey their personal meaning of their experiences and the researcher attempts to understand the participant's description of that experience. As discussed previously, it is essential that the researcher to be aware of their own beliefs and assumptions to minimise the impact of these on the interpretative process, as the role of the researcher is fundamental to this analytic process (Smith, 1996). The link and relationship between what people say, what they think, and how they feel, is another important foundation of IPA, but as Smith and Osborn forewarn, this process can be complicated as it can be difficult for some people to fully express or articulate what they are feeling, therefore an IPA researcher must use analytical, yet open questions.

The relevance of IPA to psychology, and particularly, clinical psychology, is significant, as it provides an important insight to scientist-practitioners into understanding individuals' perceptions and interpretations of their experiences, and the meanings that they assign to them, particularly with regards to individuals who have experienced some form of trauma (Mitchell, Clegg, & Furniss, 2006). IPA allows us to explore these subjective experiences, and helps us to describe and understand how the individual make sense of their experiences (Brocki & Wearden, 2006). This can be particularly useful for formulating interventions in clinical practice.

Within the qualitative research paradigm there were a range of epistemological approaches considered before IPA was decided upon for the current study. Thematic analysis was one such approach taken into consideration when the methodology was in development. This particular approach involves describing particular phenomenon through looking for patterns or 'themes' across various data sets and is not tied to a particular pre-existing theoretical framework (Braun & Clarke, 2006). Although, it focuses on the subjective human experience, thematic analysis was ultimately rejected for this study, as it was felt it would not provide the level of depth required to fully

explore the subjective lived experience of participants. Grounded theory (Charmaz, 2002) was another approach considered, but ultimately rejected during research design. This approach aims to develop a formal theory that describes the phenomena under investigation. As the aim of this study was to explore the lived experiences of participants and capture as much of their own voice within the data, grounded theory as a methodological framework was excluded, as developing a coherent theory that could account for their experiences was not in accordance with the objectives of the current study. In the same manner, ethnography was discounted as a methodological approach, as the focus of inquiry is on describing the culture of a particular group and looking for patterns across ideas and belief systems (Reeves, 2008). Finally, discourse analysis was rejected as its focus of inquiry is concerned with social contexts, in which language or discourse is embedded (Van Dijk, 1993).

As the current study aimed to explore, understand, learn from and capture the lived experiences of individuals who identify as transgender with transphobic discrimination and/or hate crime, and how this relates to their coping, IPA can be considered an appropriate framework. The objective was to explore the meaning these individuals have attached to their experiences, to inhabit their worldview and describe it accordingly.

3.4 Sampling

Participants were recruited via two organisations that work specifically with the LGBTI community, Transgender Equality Network Ireland (TENI) and Gay and Lesbian Equality Network (GLEN). The research information sheet and poster (see Appendix B; C) was distributed via social media and individuals were asked to contact the researcher directly if interested in volunteering. In total, 7 individuals expressed an interest in partaking in the research. All 7 individuals met the inclusion criteria for the project and were invited to participate in an interview. The inclusion and exclusion criteria are outlined below.

3.4.1 Inclusion and exclusion criteria

Inclusion criteria included: individuals over the age of 18, who identified themselves under the umbrella term ‘transgender’. This included anyone who identified as ‘transsexual’, ‘genderqueer’, ‘gender-fluid’, ‘pangender’, etc. In addition, individuals who were in a position to give informed consent for their participation. Exclusion criteria included anyone who was currently experiencing acute psychiatric symptoms, or who was acutely distressed from their experiences.

3.4.2 Demographic information

Table 3.1 provides basic information on participants in this study, such as their participant pseudonym and gender identity. Given the sensitive nature of this research, other demographic information, such as occupation, was not included, as it could be deemed identifiable information. The ages of participants ranged from 20-55.

Table 3.1:

Participant descriptive information

Participant Pseudonym	**Gender Identity**
Sarah	Transwoman Male-to-female
Joanne	Transwoman
Siofra	Transwoman
Megan	Female with a trans history
Jennifer	Transwoman
Jamie	Non-binary transgender
Mark	Male with a trans history

3.5 Interview schedule

This study employed semi-structured interviews with individuals who identified under the umbrella term ‘transgender’. The use of semi-structured interviews within IPA methodology is recommended to allow for a natural dialogue to emerge between the researcher and the participant. It also allows for flexibility for unique and unexpected

issues to arise within the dialogue, which the researcher can then explore further (Pietkiewicz & Smith, 2012). An interview schedule (see Appendix A) was developed by the researcher prior to research ethics submission and reviewed by both academic supervisors. The schedule was informed by the existing literature base on lived experiences of the transgender community. Interview questions were developed in accordance with the iterative process for developing an interview schedule recommended by Smith, Flowers and Larkin (2013). This process generated questions guided by the broader exploratory research question about the lived experience of transphobic hate crime and/or discrimination and how these experiences shape coping. The aim of this was to allow participants to reflect on their experiences of transphobic hate crime and/or discrimination, and explore how they coped following these experiences. The schedule comprised of initial descriptive and narrative questions around participant experiences of discrimination and/or hate crime. These were followed by questions which probed more in-depth about the impact/aftermath of incident, coping strategies to deal with experiences of discrimination, experiences of (attempting to) accessing support, and recommendations for mental health services, with prompting from the researcher if needed. Smith and Osborn (2003) reported that prompting from the researcher should only be used if/when further detail is required, as the researcher is attempting to get as much of the respondent's beliefs and perceptions about the topic, without being directed too much by the researcher. Although the schedule was developed to guide the general structure of each interview, it was not used in a systematic or formulaic approach, as each participant narrative varied in terms of depth and reflection. This involved a certain amount of flexibility on the part of researcher.

3.6 Procedure

Participants who expressed interest in the study were provided with an information sheet (see Appendix D), detailing inclusion criteria and the aims and procedure of the study, via email, and were asked to read it before giving their consent.

A pilot interview was conducted with another psychologist in clinical training, prior to participant interviews. This was to allow the researcher to become familiar with the interview structure and to evaluate the schedule structure. Based on collective

feedback from this, some structural and pacing changes were made to the interview schedule. Interviews were conducted in the boardroom of the TENI offices in Dublin. The interview schedule followed three particular stages. The first stage was a general introduction to the research and description of the interview process. Rapport was developed by answering any questions the participant had, finding commonality, and developing empathy between the researcher and participant. Building rapport with participants has been established as an integral component of the research process, as it builds a research relationship that will allow the researcher access to that person's story, and it can also have a positive effect on the subsequent development of the interview (Gill, Stewart, Treasure, & Chadwick, 2008; Dickson-Swift, James, Kippen, & Liamputtong, 2006; Ceglowski, 2000). The second stage comprised of the interview questions, and the final stage was debriefing the participant following the interview.

All participants were informed prior to their interview that their identities would remain confidential throughout the research process, and only the researcher and her supervisors would have access to their data. They were also informed that any identifying information, including place names and company names, would be removed from their data, and that they would be assigned pseudonyms. They were also informed of their right to withdraw their involvement from the study at any stage during the research process. They were also invited to examine their own transcript, following transcription of the data, to ensure they were satisfied with the content before any analysis. If they were in any way dissatisfied with the content, participants were informed of their right to withdraw their data from the study with no repercussions. Given the sensitive nature of what was being discussed in interview, participants were provided with an opportunity to reflect on their experience of the interview and if they had any further follow-up questions or comments, following completion of interviews. They were also provided with a debriefing sheet (Appendix E), which outlined details of further support if needed, in addition to the contact details of the research team.

Interviews were recorded using an Olympus Digital Voice Recorder. Following each interview, the MP3 file was transferred to an encrypted USB key on the researcher's laptop and removed from the voice recorder. Interviews were then transcribed verbatim by the researcher. Interview times for each participant are listed below.

Table 3.2:

Interview Duration

Participant Pseudonym	**Interview Duration**
Sarah	79 mins 40 seconds
Joanne	92 mins 02 seconds
Siofra	73 mins 25 seconds
Megan	85 mins 18 seconds
Jennifer	53 mins 38 seconds
Jamie	72 mins 24 seconds
Mark	63 mins 50 seconds

Throughout the research process, including data collection and initial analysis, the researcher wrote reflective memos and observation notes (see Appendix G). The purpose of these was to document any other relevant information to the study as well as providing the researcher with the opportunity to reflect on her own experiences throughout the research process. The memos were also a useful tool to refer back to during the analysis stage of the study, as they often provided some essential context during coding of transcripts. Writing reflective memos is considered a critical aspect of effectively analysing qualitative data as they can be used in engaging with the notion of creating transparency in the research process, and also for exploring the impact of critical self-reflection on research design (Smith et al., 2013; Ortlipp, 2008)

3.7 Ethical considerations

Ethical approval for the present study was received from the Education and Health Sciences Research Ethics Committee, based in the University of Limerick (see Appendix F). Neither civil society organisation involved in facilitating the recruitment process had their own research ethics committee, and both were satisfied with the ethical approval process of the University.

As outlined previously, informed consent was obtained from participants prior to commencement of data collection. The researcher obtained verbal and written informed consent while the participant read the information sheet and completed the

consent form. Participants were ensured that confidentiality and anonymity would be safeguarded through the allocation of a unique pseudonym to each participant, and only the primary researcher would have access to the document containing participant pseudonyms. Participants were also informed that any potentially identifying information would be removed from transcripts. This included named professionals, place names, company names or any other potentially identifying information. Participants were also informed of exceptions to confidentiality in the interest of maintaining participant safety both in writing and verbally. Following each interview, the digital file was transferred onto an encrypted USB stick before being transferred to a password-protected computer, with audio files encrypted and password protected. Transcription was conducted solely by the primary researcher. The primary researcher also completed any review of finished transcripts. The one exception was an independent audit of analysis conducted by a critical peer, however, all identifying information had been removed and the participant pseudonym assigned. Segments of the transcripts were discussed in research supervision between the primary researcher and both supervisors.

The current study involved exploring sensitive personal issues; the researcher was mindful of the potential for distress in participants during and post interviews. As mentioned previously, the researcher provided a list of available general support and LGBTI-specific support services for participants in the debriefing sheet. The researcher was also able to signpost participants onto appropriate services if they felt it was necessary. Participants were encouraged to contact the researcher or the principal investigator if they had any questions or comments regarding the research or their participation.

3.8 Data analysis

After each interview was transcribed verbatim, each transcript was formatted to produce three columns, as outlined by Smith et al. (2013), for the IPA analytical process. The middle column contained the original transcript text, the right column contained exploratory comments and coding, and the left column contained identified emerging themes. Under the right column, exploratory comments comprised of

descriptive, linguistic and conceptual notes. Descriptive comments were left as normal text, linguistic comments were italicised and conceptual comments were underlined (see Appendix H for an example).

Smith et al. (2013) characterised the analytical process of IPA as being governed by a set of common principles. The researcher moves from studying the particular to the characteristic, and from descriptive to the interpretative. In the current study, the researcher dedicated a significant amount of time to becoming familiar with each transcript before initial coding. This researcher achieved this by reading and rereading transcripts, while listening to the corresponding audio recording. The researcher would allow time for reflection before re-engaging with the transcript again. The periodic stages of the analytic process are outlined below.

Stage 1

- **Familiarisation with the interview transcript:**
- 'Immersing oneself' in the data by reading and rereading the original transcript while listening to the audio recording of interview

Stage 2

- **Initial Coding**
- A free textual analysis of the transcript, the aim of which is to produce a comprehensive and detailed set of notes where common clusters of meaning are developed. Exploratory notes in this level of coding are divided into three types of comments:
  - *Descriptive comments:* the focus is on describing content of what participant is saying. Is close to the participant's explicit meaning.
  - *Linguistic comments:* the focus explores the specific language used by the participant
  - *Conceptual comments:* the focus is more interpretative, and at an interrogative level

Stage 3

- **Interpretative Coding**
- A deeper level of analysis , whereby the researcher begins to apply psychological concepts and different interpretative lenses to the data

Stage 4

- **Identification of emergent themes**
- Preliminary themes and/or categories begin to emerge from the notes and comments the researcher has made

Stage 5

- **Identification of subordinate themes**
- Reflecting back on the process of analysis allows the researcher to begin to connect groups of emergent themes. Each interview is analysed and coded in detail before moving on to the next interview. The same process oultined above is repeated with each subsequent interview.

Stage 6

- **Identification of superordinate themes**
- A further level of analysis of the various themes for each interview: highlighting where there are similarities and where there are differences leading to the development of superordinate themes across the data

Figure 3.1: *IPA analytical process as outlined by Smith et al. (2013)*

3.9 Quality considerations in qualitative research

One of the key criticisms of qualitative research by quantitative researchers is failing to engage a 'representative' sample or not empirically generalising the findings to the wider sample population (Yardley, 2000). However, due to the complex, in-depth analytical process involved in qualitative research, it would prove extremely difficult to find a sample size large enough to be considered 'statistically representative', as well as engaging in the comprehensive level of analysis necessary. No small sample size of data can adequately represent the larger sample population (Yin, 2015). Downplaying 'statistical generalisation', qualitative researchers prefer to use the term 'transferability' when discussing their findings. As with analytic generalisation, transferability implies that the research findings can be transferred to other settings beyond the scope of the study context (Jensen, 2008). Although the current study involved sampling from a minority population, the sheer amount of diversity within this population meant that gaining an adequate 'representative sample' would prove problematic. Therefore, the findings of this study will be discussed in terms of 'transferability', rather than 'generalisability'.

In addition, on the recommendations of Smith et al. (2013), the current study applied Yardley's (2000) guiding principles for establishing quality in qualitative research. This acted as a guide for determining quality in existing qualitative literature, as well as in the current study's methodological design and analytical process. Validity and quality were critically appraised by the researcher within the following principles: (1) Sensitivity to context; (2) Commitment and rigour; (3) Transparency and coherence; (4) Impact and importance.

3.9.1 Sensitivity to context

This was demonstrated in various different ways throughout the research process. The researcher engaged closely with existing related empirical literature in relation to

transgender individuals who have experienced discrimination and/or hate crime. The socio-cultural milieu provided an integral backdrop to this study and was reflected on throughout the research process. During data collection, acknowledging and reflecting on the socio-cultural context, was considered a vital component for establishing rapport with the participant. The social context of the relationship between the researcher and participants was also considered. The position of the researcher (a cisgender female, a psychologist in clinical training, and an employee of the health service) in relation to participants, gender identity and expression, and in some cases, age, were noted by the researcher and reflected on, both with participants and in research supervision. This will be discussed further in the reflection on the research process. During the analytical process, the researcher further established sensitivity to context by making significant efforts to establish connections between the findings of the current study and those of the existing literature.

3.9.2 Commitment and rigour

Commitment to, and the meticulousness of the research process, on behalf of the researcher was demonstrated through ensuring the quality of the study methodology. The researcher attended academic workshops on qualitative research design and qualitative data analysis. Throughout the research process, the researcher also engaged in research consultations with fellow researchers utilising IPA methodologies, and utilised research supervision to critically appraise the methodological approach. Furthermore, within the IPA framework, the researcher was very cognisant of the level of skill needed to conduct experiential qualitative research. Particular attention was paid to the process experienced by each participant and the researcher attempted to involve each participant as much as possible throughout the research process. As research with various minority populations is currently very topical, there is propensity for 'drive-by research', whereby findings are not disseminated back to the community. In this study, commitment to the participant process was shown by inviting each participant to review and reflect with the researcher at various points throughout the research process. Participants were invited to review their own transcripts, and a preliminary discussion of the findings were

discussed with each participant, once it had been critically discussed during research supervision.

3.9.3 Transparency and coherence

It is hoped that transparency has been achieved with the above detailed description of the process involved in selecting participants, how the interview schedule was developed and conducted, and the steps involved in the analytical process. In a further effort to ensure transparency and coherence, an independent audit of the data trail was carried out by a critical peer. The independent audit was not to establish inter-rater reliability, but rather that the findings established by the researcher were viable and credible. Said critical peer achieved this by: establishing the accuracy of verbatim transcriptions, evaluating the appropriateness of initial notes and emergent themes, as well as appraising the suitability of established superordinate and subordinate themes. Regular critical discussions with both supervisors also provided the researcher with the opportunity to self-audit at multiple junctures throughout the research process.

3.9.4 Impact and importance

It is hoped that the findings of the current study will provide a deeper insight into the subjective lived experience of individuals who identify as transgender and have experienced transphobic discrimination and/or hate crime. It is hoped that this research will address and begin to bridge the gap in existing literature, as well as serving as a foundation upon which future research endeavours can be based in the effort to fully understand this phenomenon. Given the current socio-cultural milieu, the exponential growth of hate crime incidents on a global scale, and the gathering momentum advocating for legislation of hate crime in Ireland, it is hoped that this research can serve as a beginning to understanding what it is like, from the perspective of the individuals who live with this hostility every day. This study also provides a much-needed feedback and a valuable learning opportunity for health care professionals across various disciplines that work with transgender people. The findings of this research have the potential to act as a sounding board to improve how particular services in Ireland advocate and support transgender individuals.

3.10 Reflection on the research process

Reflexivity is an important process to consider when utilising an IPA methodology. Smith et al. (2013) recommended that the researcher be very cognisant of their own role in the process of collecting and analysing data. A researcher's own held beliefs, assumptions, biases and understandings could both encourage or hinder the research process if they are not mindful of these (Smith, 2004). By openly acknowledging and recording predisposed beliefs and assumptions, the researcher can hopefully minimise their influence during the data collection and analysis process.
The current social climate is what initially drew me to this particular topic. Throughout this process, I have become keenly aware of how progressive certain aspects of society has become in its treatment of members of minority populations, and yet also how much it has regressed in recent months. At the time, what interested me most were the individuals themselves and how they made sense of the difficulties they experienced. Although I felt it was vitally important to gain further insight into the impact of these experiences on individuals, I also wanted to shed some light on how these individuals coped in the face of this adversity.

Throughout the process, I was very mindful of my role as both a researcher, but also as a Psychologist in Clinical Training. As many individuals who identify as transgender often have to engage with mental health professionals, particularly psychology, as part of their transition process, the community can often view psychologists as 'gatekeepers'. Originally, I was concerned my role as a Psychologist in Clinical Training would impede the data collection process, particularly during the interview, as I was unsure whether participants would feel comfortable to discuss their opinions and views. However, this fear proved to be unfounded, as all participants were very willing to speak candidly about their own experiences. However, this in turn, made me conscious of my position as a health service employee. Participants often spoken frankly about their experiences of engaging with the health service, and not all of this was particularly positive. However, I became aware that what emerged from the findings could serve as valuable feedback to the health service and have significant implications for practice.

Overall, I felt the research process proceeded well, and the interviews provided a significant amount of depth on transgender individual's experiences of discrimination and/or hate crime. In addition, I felt that variation in individual experiences was captured and explored. Another challenge concerned the interview process itself, where I felt the boundaries between my role as a researcher and my role as a clinician were unclear at times. As the interview process proposed discussion on, in some cases, very traumatic events for these participants, it was difficult at times to remain the consummate 'outside observer' as a researcher. However, I discussed this regularly in research supervision and was mindful of this during the analytical process.

Finally, with regard to the data analysis process in IPA, I found this process challenging, simply due to my lack of prior experience with it. I found myself following the Smith et al. (2013) recommendations very closely, and I felt I spent a significant amount of time getting to grips with what the process of analysis entailed. Whereas my previous experience of research had warranted predominantly quantitative approaches, I found the transition from a clear and explicit process to a more descriptive and interpretative form of analysis and lack of set criteria for data interpretation quite demanding. During the initial stages of analysis, I was concerned that my analysis was more descriptive than interpretative, and worried that I was simply 'seeing what I wanted to see' in the data. However, as I became more familiar with the process, I realised that IPA acknowledges the collaboration of participant and researcher with the data and the aim is not to capture a definitive account of participant experiences. However, I addressed my initial concerns by enlisting a critical peer to undertake an audit of the analysis trail, as well as critically reviewing my analysis with both supervisors.

CHAPTER FOUR: FINDINGS

4.1 Chapter introduction

A number of themes emerged from the 7 interviews. The following chapter presents the research findings in the form of superordinate themes and their corresponding subordinate themes. Within each superordinate theme, a summary of the constituent findings will be provided, as well as an interpretation of their meaning and significance[1].

4.2 Overview of findings

Research participants provided a contextual description of what their life was like as a trans person. They described experiences of transphobic discrimination and hate crime or hate incidents. The meaning and significance of these experiences was explored in discussions of their emotional and behavioural impacts. Participants provided rich descriptions of the processes they experienced and strategies they employed in the aftermath of experiences of hostility.

Analysis of the seven interviews conducted identified three distinct superordinate themes (see Table 4.1)[2]. 'Psychological impact of experiences', the first superordinate theme, describes the impact of experiences of transphobic discrimination/ hate crime on them as an individual and how they responded on an emotional, physical and cognitive level. 'Coping', the second superordinate theme, involves how participants described how their coping strategies following these experiences, whether this was drawing on internal coping mechanisms, or seeking external support. Participants described varying experiences of seeking external support, and for that reason, this subordinate theme has two minor themes which elaborate these differences.

[1] For the purposes of this chapter, the use of three full stops in participant quotes indicates the removal of some text. This was done to aid the clarity of the point being expressed by the respective participant.

[2] 'Experiences of transphobic hostility' is not treated as a 'superordinate theme' - but provides the context necessary to interpret the significance of the various coping strategies and sources of resilience described.

The final superordinate theme, 'Resilience' involves how participants described moving on from these experiences and what influenced their resilience. The majority of participants described experiencing some form of post-traumatic growth following their experiences, and finally, provided some feedback for developing appropriate and supportive services for trans people.

Table 4.1

Summary of superordinate, subordinate and minor themes

Experiences of transphobic hostility

Superordinate Theme	**Subordinate Themes**	**Minor Themes**
Psychological impact of experiences	**Emotional response** **Thought processes in response** **Impact on behaviour**	
Coping	**Internal coping strategies**	
	Experiences of seeking external support	**Positive experiences**
		Negative experiences
Resilience	**Post-traumatic growth**	
	Meaning of resilience to the individual	
	Developing trans-inclusive services	

4.3 Setting the context for life as a trans individual

Participants described what it was like for them as a trans person growing up. All participants described the difficulties they experienced, particularly as children, just for 'being different'. Many felt that although they recognised from an early age that they were different from everyone else, they didn't have the language as children to verbalise how or why they felt different. All described the struggle they experienced with how they identified, and recognised the discrepancies between how they identified and how they were expected to present. The majority of participants described growing up in tumultuous environments, whether in a family home characterised by difficult dynamics between family members, or being bullied in

school for presenting in any way that did not conform to the norm. All participants recognised the influence of cisnormativity, transphobia and gender duality (Holmes, 2016) on their lives, reporting growing up in a society where diversity was not encouraged and actively looked down upon. In line with international literature on the relationship between transitioning and ambiguous loss (Norwood, 2013), participants spoke about experiencing a sense of loss across various aspects of their lives as a result of their transitioning. Every participant described a breakdown of some form of relationship either following their coming out, or throughout their transition process. This included loss of family relationships, friendships and partner relationships. All spoke about how isolating it was to be a trans individual and the continuous marginalisation they felt for being trans**.**

4.4 Experiences of transphobic hostility

The below figures provide a classification of the types of experiences participants were subjected to. Figure 4.1 refers to hate incidents, whereas Figure 4.2 refers to experiences of discrimination. Reflecting international research findings regarding the prevalence of repeat victimization among trans people (Williams & Tregidga, 2014), all participants had experienced multiple incidents throughout their lives. Although the underreporting of victimisation is recognized as a particular problem in the trans community globally (Gilles, 2011), it was nonetheless disturbing that none of the participants had ever reported an experience of hostility to the authorities. Although the manifestations of hostility that they experienced varied, verbalisations of transphobia and cisnormativity, as well as misgendering, were common across the incidents described.

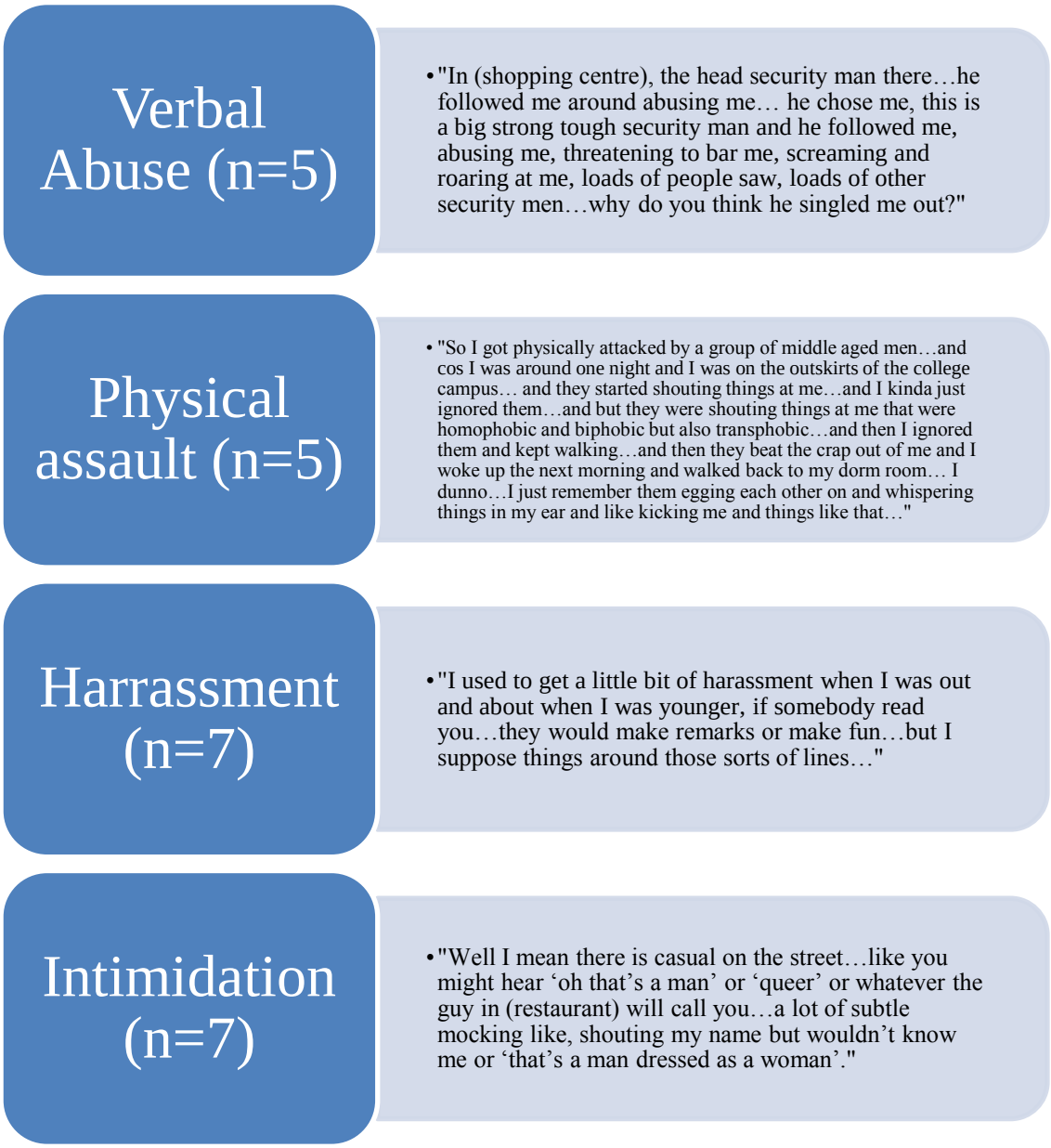

Figure 4.1 Experiences of hate crime and hate incidents as reported by participants ('n' referring to number of participants who described the incident)

Figure 4.2 Experiences of discrimination as reported by participants ('n' referring to number of participants who described the incident)

4.5 Superordinate theme: Psychological impact of experiences

Figure 4.3 Breakdown of superordinate theme 'Psychological impact of experiences'

All participants described having a significant traumatic response to their respective experiences of discrimination and/or hate crime. In the context of this study, a traumatic response is characterised by emotional, physical, behavioural reactions and specific thought processes (Schneiderman, Ironson, & Siegal, 2005). Different participants experienced their respective trauma response occurred at different stages; in some cases in the moment, in other cases immediately following the trauma, or over a significant period of time following the event.

4.5.1 Subordinate theme: Emotional response to trauma

Helplessness

In the moment of their experiences of discrimination and/or hate crime, many participants described feeling helpless and powerless during the commission of a discriminatory act and/or hate incident. One participant described helplessness as a dual process. They experienced helplessness when they were physically assaulted by a group of men, but also felt powerless to seek help or to seek justice after the incident.

"Then knowing I couldn't talk to the police about it, so I couldn't feel safe, I couldn't turn to my friends about it..." (Jamie, p.13)

The helplessness described here is more significant in that for Jamie, their previous experiences of seeking help from the system had led to secondary victimisation, and following this, they no longer felt trust in the system to be able to help them. This meant that Jamie felt they had nowhere and no one to turn to, further increasing their feelings of helplessness.

Victimisation

Every participant felt personally victiminised in response to their experiences of transphobic discrimination and/or hate crime, in that they felt they were made to feel a victim by someone else. For some, personal victimisation meant feeling excluded and marginalised from various different social groups.

"You're sorta included as one of the girls, you have been for years and years and years…and yet a question like that excludes you… and then you're knocked back, and you're thinking well nobody really understands and you're still excluded." (Megan, p.2)

Most participants described feeling deliberately neglected and diminished by cisgender individuals or by a system. On describing her experiences with a state body, one participant stated that felt she was trying to fit within the parameters of a system that could not and would not recognise her.

"So when they're making mistakes, when they're screwing up, that effectively puts me back into that box, You have to be this person while we're doing the paperwork, you've have to fit within these parameters inside this box that we've created…and you find yourself feeling very hemmed in and having to conform." (Siofra, p.5)

This participant didn't just feel let down by the system, she felt disillusioned and abandoned. For her the experience of not being recognised by the state was an experience of being deliberately segregated from everyone else for not fitting in.

"To be let down by somebody, would imply neglect or overlooking somebody…I feel like I've been shoved through the cracks…. there's letting somebody

down, there's letting somebody fall and then there's looking at somebody and saying 'you're different, go over there'." (Siofra, p.8)

Fear

One of the most significant emotional responses experienced by all participants was fear. Although fear was a universal response across participants, the degree, severity and impact of the fear ranged with each individual. For Joanne, her experience of being physically attacked made her more anxious about going out in public, particularly at nighttime, for a considerable period of time following the incident.

"Afterwards, it made me very unsure about going out on my own it had that effect on me…but it made me kind of wary about going out on a Friday or a Saturday night you know?" (Joanne, p.5)

For another participant, the experience of being subject to threatening, abusive and insulting behaviour in a public place caused a significant traumatic response. She described feeling incredibly distressed immediately following the incident but even in the subsequent weeks and months after the incident she described getting regular flashbacks of the incident, which would cause her anxiety to increase significantly.

"I was crying all day long and I regularly get flashbacks of that man screaming at me, following me around. I wake sometimes and it pops into my head…" (Sarah, p.10)

She explained that even simple mundane tasks could act as a trigger for her anxiety, each time acting as a re-traumatisation of the event for her. This also indicated the significance of the trauma response for her. Although the incident had occurred a number of years previously for this participant, the experience of describing it in the interview elevated her anxiety in that moment, as a result of which she needed some time to manage before being able to continue.

"Yeah I could be just in the shower, in bed, I could be just up in the morning making my toast and it just pops into my head…and I can go into it meandering and that causes anxiety as well…it would raise my blood pressure and anxiety levels a little bit without even realising it." (Sarah, p.18)

A third participant had experienced significant levels of discrimination and had multiple experiences of being a victim of hate crime. For them, living with anxiety became the norm and they had almost become accustomed to living in a perpetual state of anxiety.

"Like I've spent my whole life scared, and I didn't realise how scary it was until I had something to compare it to…" (Jamie, p.12)

They described being hypervigilant in public and expecting attack at every turn. They described having a panic attack in response to their partner trying to hold their hand in public.

"I had a panic attack and I freaked out and I was like they're gonna kill us, and was looking around saying what are you doing, you're gonna get us attacked like stop…and it took me like 2 weeks to like actually hold their hand in public…" (Jamie, p.8)

Depression

Another emotional response described by most participants to their experiences was low mood and depression. Both were emotional experiences that many participants struggled with at various points throughout their lives, but were always in response to their experiences of discrimination and/or hate crime. Across participants it became apparent that sadness was not something that they experienced as a response to one particular incident. For most, it was the consistency of experiencing transphobic discrimination at many levels and over time that caused significant despair and persistent low mood.

"I suppose I know what bad times are like, I know what it's like to be at the bottom, to be on the floor to am…I know what it's like to despair" (Sarah, p.21)

"I felt that I wasn't strong enough…I felt like I would never get anywhere…I've had many times…I've felt what's the point because my life is screwed anyway…because I will never get what I need, and because if I ever do, it's gonna be a complete disaster…" (Mark, p.14)

For every participant, the experience of regular transphobic discrimination triggered persistent feelings of anxiety and low mood. The continuation of experiences would

re-trigger previous feelings of anxiety and low mood and the vicious cycle would continue. For many, the consequences of living in this persistent state of stress led to them experiencing 'burnout'.

"There are obviously days where you just feel tired and exhausted and it does, I wouldn't say depressed, but you do feel a little bit down, and you do feel a little bit, because it is quite exhausting to have to live with all the time." (Jennifer, p.7)

"I was burned out, mentally and physically having gone through all of that for the previous 3/4 years and I just got to a stage where I thought I need a break." (Joanne, p.15)

"I'm not easy to scare, but this has gone on for so long, that the attrition rate of it, and the fact that you can't fight it, you can't fight the inertia of the system as it's just mindlessly doing what it does… so yeah that destroys you." (Siofra, p.5)

4.5.2 Subordinate theme: Thought processes in response

Every participant described some form of negative self-questioning and internal scrutiny in response to experiences of hostility, whereby they questioned what they might be doing wrong, and what they could do to best 'fit in' to prevent future victimisation.

"Well it had the effect on my confidence, it had the effect of making me, as Rory O'Neill said 'checking myself at the level-crossing', it made me sort of start to think 'what am I doing wrong here? What did I do that gave me away? For the first time in 10 years…what did I do wrong?'" (Joanne, p.5)

Having described herself as previously being quite self-assured, this participant described internalising her experiences and starting to question herself, as to whether she might be at fault. For a second participant, her self-questioning process involved her fantasizing about whether her life would have easier if she had just been born female.

"Now I still don't understand it, you know it's a sort of why me...it's difficult and you sort go, you wonder, whether things would have been easier if you were born female." (Jennifer, p.5)

A third participant similarly spoke about questioning himself and his choices, and whether or not he made the right choice in transitioning.

"So you kind of rethink your life and your priorities, trust me (laughs)…so there will be a moment where you ask yourself, why the fuck did I do this…" (Mark, p.13)

Participants described here was the impact of this self-questioning as lasting feelings of intense self-doubt, even to the point where they questioned the choices they made that had led them to that particular point.

Every participant discussed contemplating suicide at many points, or had acted upon suicidal thoughts following their experiences.

"The thought did enter into my head…I mean would I be better off ending it now, I didn't go into great detail, I didn't plan suicide or anything, I did decide I'm not gonna do it but the thoughts did enter my head 'would I be better off, is this how it's gonna be?'." (Sarah, p.21)

"So there have been times where I just didn't want to live because I thought there would be no point…I did try and take my own life…I obviously didn't make it…or I wouldn't be here." (Mark, p.15)

4.5.3 Subordinate theme: Impact on behaviour

Participants spoke about the manner in which cumulative experiences of their emotional and thought responses led them to deliberately isolate themselves. The isolation differed in function for participants. One participant did not want to burden their friends by seeking help from them and felt that by telling them, they would be causing their friends significant distress. This participant was not out to their family and was unable to contact the police due to previous experiences of secondary victimisation. They felt they were better off managing their pain and distress on their own.

"Like I can't tell my friends about it because then my friends will be too scared…and I was like don't want them to be scared…I can't ruin their lives like that

*and I can't tell the police, I can't tell my parents because they don't know I'm trans…"(*Jamie, p.7)

A second participant states that, she was aware that she deliberately isolated herself from people in order to shield herself from further experiences of discrimination and hostility.

"But again I suppose, maybe I've isolated myself, maybe I should be more part of it and have more of a say…you know." (Megan, p.9)

A third participant felt so alone that she was convinced that no one would be able to help her if she sought care, and that it would be more of an effort to reach out than it would be to manage her pain by herself.

"And there's no salve, there's no painkiller you can take for it…it just seems like an excess…it just seems like something I don't need to do, or don't want to do…I will isolate…occasionally I will withdraw…" (Siofra, p.16)

Participants spoke about how repeated incidents of discrimination and/or hate crime made them extremely wary of others when they went out in public or when dealing with a public system or state body. The participant quoted directly above spoke about how her lack of faith in the health system and justice system following negative experiences with them made her less likely to seek help. She anticipated that she would be more likely to experience secondary victimisation within the health system or justice system and therefore decided against linking in with services.

"And I the reason I didn't go (to A&E) was because I didn't want to deal with explaining to people that, I didn't want to have to go in and go 'ok here's the thing', have them look at me and then immediately begin misgendering me…" (Siofra, p.8)

"We can't go to the police…because by in large, you will be confronted with the attitude of 'it's your fault'." (Siofra, p.14)

Her previous negative experiences of seeking help, coupled with her consequent anticipatory fear of rejection, prevented her from accessing help when she needed it. She also discussed how the impact of her anticipatory fear could put her at higher risk of repeat victimisation.

"But what I find is that there's a sort of self-fulfilling nature of perceiving that everybody's going to cause you a problem and thus everybody causes you a problem." (Siofra, p.12)

Similarly, a fourth participant recognised how his own anticipatory fear of being attacked or discriminated against was actually causing more distress for him and exacerbated his thoughts and feelings of fear. He perceived that he was anticipating attack in situations and scenarios where he was actually safe.

"I realised that most of the times it was me building up the issue and problems where there were none because if I just stopped and realised that nobody actually cared about me…I lived in (area) for a very long time and you would expect that people would be a little more close minded over there…" (Mark, p.7)

The stress of constantly anticipating some form of attack or being on high alert was closely linked to the experiences of burnout described by participants. Living in this constant state of stress and fear is something that was very familiar to the trans people in this study. A fifth participant reported feeling anxious when she went out in public as she anticipated what others might be thinking of her, whether they might pass comments or begin attacking her.

"I'm afraid that people will say 'oh that's a man', or start abusing me in some way, they'll attack me or tell me to get out or something." (Sarah, p.14)

She recognised that her anticipatory fear caused her to behave differently in public than she would normally and questioned whether her behaviour drew more attention to her than the fact that she was a woman with a trans history.

"Because of that experience in (shopping centre)…it made me nervous…it caused me to behave differently, which actually drew attention to myself…when there may not have been any need to…had I just behaved…had I just went about my business like most people…" (Sarah, p.15)

4.6 Superordinate theme: Coping

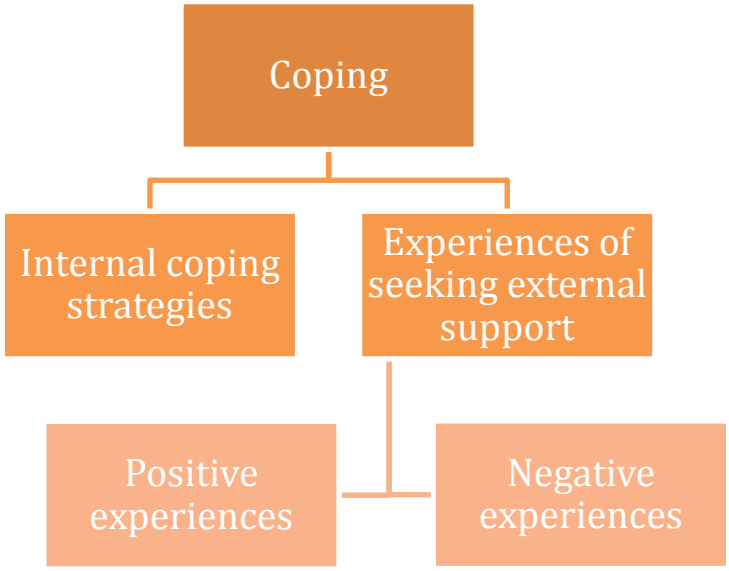

Figure 4.4 Breakdown of superordinate theme 'Coping'

In the aftermath of their trauma experiences, participants described their coping in terms of a reactive response in order to manage the distress caused by the stressor(s). Coping strategies were broken down into two distinct but overlapping models of internal coping strategies and external sources of support. Participants reported differing experiences of externally seeking support; hence both positive and negative experiences are discussed.

4.6.1 Subordinate theme: Internal coping strategies

Internal coping classified into three categories: problem-focused coping, emotion-focused coping and appraisal-focused coping strategies. Although appearing as distinct categories, participants described using a mixture of all three strategy categories and specified that their coping skills and what strategies they drew on changed over time. For the purposes of this study, coping strategies will not be labelled as 'adaptive' or 'maladaptive', as participants indicated that certain

strategies, worked for them at that particular point in their lives and reduced their distress.

Problem-focused coping

For some the best way to cope was to try to deal with the cause of their stress in practical ways. As discussed in the literature review, problem-focused coping is an approach which tackles the problem or stressful situation that is causing stress, with the aim of reducing the stress (Lazarus & Folkman, 1984). As problem-focused strategies tend to stem from what the individual can control about their situation, the capacity to employ this approach is limited in any situation where it is beyond the individual's control to remove the source of stress. For the trans people in this study, there was very little to control in terms of their circumstances or scenarios. For example, not all participants were able to take control of a situation, or perceive a situation as controllable. Therefore, participants spoke about utilising practical methods such as conforming to societal norms, avoidance, and self-checking behaviours as aspects participants felt they could control about themselves.

Participants described using avoidance of people and places as a means in which to help themselves feel safe.

"I don't mix with them much…but I'm sure most of them still refer to me by my old name…I deliberately don't interact with them anymore than I have to." (Sarah, p.6)

"You lock yourself away, and that's the danger I suppose if you have really bad experiences, if you feel that the world is against you and so many bad things happen to you, the danger is you might hide yourself away, lock yourself away and I dunno where you'd go from there" (Sarah, p.22)

Trying to conform to societal norms was another way participants tried to reduce their likelihood of repeat victimisation. Participants described trying to mask what they felt were obvious features to try and blend in and 'pass in society'.

"But I will tell you that as soon as I walk through the door, I change the way I walk, I change the way I hold my head, I change the way… I swallow my Adam's apple, I will not say a word, because I know those things will out me." (Siofra, p.10)

"I spent most of my life not being true to myself, trying to conform and play by society's rules and just get along." (Jennifer, p.4)

Similarly to conforming, participants described engaging in self-checking or safety behaviours such as checking their make-up before going out to help reduce their anxiety and help them feel more confident about 'passing in public'.

"It's always something you do, you know, it's always something you do…you consciously check yourself before you go out the door and I think everybody does that, it doesn't matter if they're trans or female or whatever, everybody goes 'is my hair alright?' we all do that, there's a mirror in the hall, you go out and look at yourself and think 'is my make-up ok?'" (Joanne, p.24)

"You'll double check your make-up 5, 6, 7 times in the mirror as you're walking by…" (Siofra, p.11)

All these methods were mechanisms that allowed participants a greater perceived control over their stressor.

Emotion-focused coping

Participants described trying to reduce the negative emotional responses they experienced as a result of the stress and trauma, such as embarrassment, fear, anxiety, depression, and frustration. Whereas problem-focused strategies are limited when the individual has little control over the situation, emotion-focused strategies were often a more realistic option for participants when the cause of distress was outside of their control.

Similar to avoidance, one of the ways most participants described managing the negative emotional responses was distancing themselves emotionally from people with various different outcomes. Distancing referred to an emotional dissociation from others, more so with regards to close relationships (i.e. family and friends), whereas avoidance for participants referred to a more physical avoidance of people and places.

"It's scary…it is quite scary and I suppose you sort of build-up defences and you sort of, you probably move a little bit away from people and I tend to sort of keep myself to myself." (Jennifer, p.5)

"So I really pushed everyone away and tried to handle it on my own but at the same time it was because I really felt like I didn't really deserve any sort of…help or acknowledgement." (Jamie, p.13)

Distancing themselves emotionally was a way for participants to give themselves some space to react, consider their options, however although both participants quoted above described it as a necessary mechanism at the time, both reflected that moving away from people did not actually reduce their negative emotional responses but rather made them feel more isolated and low.

Some participants described a process whereby they chose not to engage or talk about their distressing feelings or thoughts - by suppressing them.

"*So I tend not to worry, I tend to, I have a mechanism where I see myself putting a problem into a box in the back of head, locking it and leaving it there and I don't bring it out and look at it."* (Joanne, p.22)

"I'm very good at compartmentalising stuff…I sort of put it to one side thinking you know, oh I'll just put this away, and box that up…but that was both naïve and stupid…that can't be done… generally if I don't want to think about something I won't think about it…I'll just put it to one side…" (Jennifer, p.6)

Suppressing these was a way for Joanne and Jennifer to put off dealing directly with the trauma at the time. However, Jennifer again reflected that suppressing her thoughts and feelings did not always work for her, whereas for Joanne, suppression was the only way for her to manage her negative emotions.

Appraisal-focused coping

Most participants also described using appraisal-based coping methods, which were directed towards cognitive restructuring whereby they challenged their own assumptions and modified the way they thought about the stressor/scenario (Lepore & Greenberg, 2002). All described some of self-reflection as an invaluable means of

managing the trauma; whether this was reflecting on the positives and looking at the bigger picture.

For those who described reflection on positives, for them, reframing how they thought about their experiences allowed them to focus on more positive aspects of their lives, and come to a greater understanding of what life meant to them.

"Now I'm 34 now, I know that the world doesn't actually work that way, that there are people out there who do care and who do genuinely care and there are people who can't help themselves when it comes to caring…and there's a lot of those…" (Siofra, p.17)

"My sadness is still better than a lot of people…I still love my job, I'm not happy now, I'm going through a lot of shit…but I still want to be here…" (Megan, p.27)

"Yeah like moving here, it is a relief, I don't feel as scared, I don't feel like I have to constantly fear for my life…I don't feel like I'm gonna be attacked at every second…which is nice…" (Jamie, p.13)

Reflecting on the bigger picture involved participants focusing on how far they had come in their journey and what they had achieved and how reminding themselves of this gave meaning to them.

"So remind myself how far I have come, remind myself of where I'm going, how things will be even better in the future hopefully… if I get a severe bout of anxiety and I'm in Dublin….and I've come through them before…then what's the worst that can happen…I may end up lightheaded or dizzy and I may feel like absolute crap but nothing bad is going to happen…" (Sarah, p.38)

"…to have survived all that…sometimes I need to stop and go, look at what you've just achieved, look how far you've come, look what you've done?!" (Jennifer, p.7)

Some participants found that accepting rather than ruminating about their experiences helped them to come to terms with it. They spoke about acknowledging that the experience was extremely difficult, but that it happened and they could not change it. Those who described using acceptance reported finding the energy it took to ruminate

over the experience for more taxing than simply accepting that it happened to them. For Sarah and Joanne, acceptance meant that they chose to let go of the situation and move forward with their lives.

"*Funnily enough I have come to a greater acceptance of it, I just, the people worth having in my life will make the effort anyway."* (Sarah, p.8)

"You just have to get used to it over time and just say 'hey whatever', I think that's the only way you can deal with it, you can't let it get to you…" (Joanne, p.24)

4.6.2 Subordinate theme: Experiences of seeking external support

4.6.2.1 Minor theme: Positive experiences

Participants described building a connection with one or more supportive communities as a hugely significant aspect that contributed to their coping. Whether this was partners, friends or family members, all participants relayed that at different points throughout their lives they felt the need to open up and seek support from others.

"I have my friends and I have what we call our 'ohana' which is our family…. So you find yourself relying on friends within the community…by which I mean, your personal friends so I have a few trans women and a few trans men, and a bunch of non-binary people. I have my partner, and I have my ohana…and that's it." (Siofra, p.13-14)

"I have a few good friends on twitter who are very, very supportive… and my sister has been very supportive and obviously my friends on twitter have been extremely supportive you know…they were sort of the first people I came out to…" (Jennifer, p.5/7)

(On her partner) *"So she would challenge me to talk about the issues and bring the issue out and that's why she's good for me, because she makes me think and that's one of the good things we have because she actually makes me take the stuff out of the boxes, instead of ignoring them, make me think about them and actually do something about it…"* (Joanne, p.23)

Linking in with support organisations was also something that the majority of participants found to be a positive experience, as these communities helped encourage them when they felt overwhelmed and less resilient, and also provided some information and clarity when needed.

"Yeah well I went to (provincial grassroots service), they were very good, they gave me free counselling for a while… but (counsellor) was just very very good, she was very supportive, very strong in her support, she was great." (Sarah, p.32-33)

"I also have, especially in Ireland I have more support…especially support organizations to kind of get information and feedback and resources from…" (Jamie, p.1)

Some participants also described the benefits of attending personal therapy and found it to be a vital part for their coping in terms of learning to live and moving on from their experiences. It is important to note here that only some participants discussed the benefits of external support, as others reported having predominantly negative experiences of seeking external support, which will now be discussed.

"I do need regular access to a therapist or somebody who will listen to me every couple of weeks, I think I do need that, and I think I will always need that." (Sarah, p.37)

"Counselling has helped an awful lot, I do sort of talk these issues through with my counsellor…and she's been very, very supportive and just she doesn't offer solutions, but just talking about it with people just helps massively you know" (Jennifer, p.5-6)

4.6.2.2 Minor theme: Negative experiences

All participants spoke about experiencing secondary victimisation when they tried to seek support from state service providers, particularly from the health service. Many felt that dealing with government organisations for processes like trying to get their details changed, even following the Gender Recognition Act, was extremely arduous and very difficult.

"It was a nightmare… and they made all kinds of promises about how there would be a seamless system and how things would be handled, and how there would be no economic barriers…all of it was a lie…every bit…. I feel like they know, at least they should be aware that as a trans person, I'm much less likely to be employed, therefore I'm less likely to have an income and therefore less likely to be able to pay for these things…" (Siofra, p.2-3)

Participants reported that when they tried to seek support from systems such as the Social Welfare office or the Department of Social Protection, they felt like they were being discriminated at the highest level, and that they were trying to fit into a system that didn't recognise them or was unwilling to cater to their needs. Two participants made references to feeling that the structure of the system completely marginalised them from society, and that it was unfeeling to the distress it caused them.

"It's effectively the state telling you 'you don't exist, we don't care that you paid us to recognise this, we don't care that we made a mistake and we want you to go and spend more money to pretend to be a person that we're legally requiring you not to be…so you have to break the law…you see this is the thing…the whole thing tumbles completely out of control…and they look at you like it's your fault, like you've caused a problem!" (Siofra, p.4)

"But when the government has been saying to me my whole life 'well you don't exist, you don't matter'…therefore everything next outside of that, is a problem because you don't exist in the first place…and I find that a big issue… It's a piece of paper that doesn't reflect anything got to do with me…but I didn't want to bring it because I haven't associated with that birth cert in like forever in my head, but you're being forced into it, and then you reach out for help…and you're told 'well you'll just have to do it if you want social welfare'" (Megan, p.7)

For the former participant in particular, she found that her experiences of dealing with the state, made her feel very marginalised and isolated because of who she was, how she identified and because this did not conform to the state system. She spoke about these experiences as the most damaging for her psychological wellbeing. However for this participant, feeling discriminated against by a system that was meant to protect her, was especially damaging to her, as it felt deliberate.

"This is where it's supposed to stop hurting, but it doesn't, it's where the hurt really starts happening…it's the deliberate aggressions, macro-aggressions from the state, from organisation which probably hurt more than anything else." (Siofra, p.9)

The participant felt that state support was contingent on whether she conformed to a gender with which she did not identify. For her, there was a knock-on effect whereby if she did not conform to what society and governmental systems wanted of her, she would lose her rights as an individual. This caused her significant distress, and further isolation.

"That if you stray outside these parameters, you lose benefits, you will lose credibility, you will lose help, you will lose access, you will lose your rights and that's terrifying." (Siofra, p.6)

Most participants described their experiences of engaging with the health system as predominantly negative. They felt that being transgender meant there was no place for them in the boundaries of the healthcare system. A typical example being that most still found it difficult to identify themselves on medical forms as anything other than male or female. Even while engaging with trans-specific services, participants felt their interactions with staff and the lack of inclusivity in services was hugely damaging to their psychological wellbeing. Participants reported regular experiences of being misgendered and healthcare professionals continued to use their 'dead-name' even after they had updated their information.

"But I know how it makes me feel when I go in there…and I remember the way I've been treated by so-called professionals nurses and doctors…where you're misgendered from the moment you walk in the door, when even after you've updated all of your information…when your file has a 'F' where there used to be a 'M' and they still say 'he' and still dead-name you." (Siofra, p.9)

People felt that healthcare professionals who they expected to be able to work with them often presented with a complete lack of understanding of their situation, as they never had consistent contact with the same healthcare professional. This lead to participants feeling that they had to re-out themselves with every new encounter and repeat their story over and over again.

"I would say the worst stuff that I've experienced has actually been in the clinic…and that's only because I heard doctors talking, not necessarily about me, but about other transgender people, referring to them, so a FTM as a 'she', or MTF as 'he'…apart from the service which is a pure disgrace, because you never get to see the same person….so they never know who you are, why you're there, what's your history and what you need…but the most worrying thing is the attitude of the doctors…they're polite towards you when they talk to you…I don't think they're taking it very seriously, I don't know what their real thought is…" (Mark, p.3-4)

"Still within the HSE, no matter which doctor I'm talking to or which nurse, I can tell you from being within (service name), I have a new doctor, new nurse every single week…no one reads the, my file, so I have to out myself to them…" (Siofra, p.6)

Participants also felt that they were subject to intrusive, and sometimes very unnecessary, examinations as a condition of their treatment, which was highly embarrassing for them, and diminished their trust in their system. The former participant in particular, felt that he was questioned unnecessarily about his sexual orientation, which he felt was completely irrelevant to his gender identity.

"Well I was discouraged at first because I remember the first appointment was absolutely disgraceful, because they asked me all sorts of questions that I didn't think were nowhere near related to why I was there…and they had nothing to do with you being transgender…they asked me about how I had sexual intercourse with people…what my fantasies were…what my preferences were…" (Mark, p.5)

4.7 Superordinate theme: Resilience

Figure 4.5 Breakdown of superordinate theme 'Resilience'

Moving forward from, and life after experiences of discrimination and/or hate crime, was something all participants were eager to discuss. Although every participant varied in terms of where they were in terms of their transition journey, as well as in their management of post-traumatic experiences, each participant was able to reflect on particular strategies they felt helped them in terms of both living with, and moving on from, the trauma. In particular, participants spoke about experiencing some form of post-traumatic growth as a result of the adversity and trauma they had dealt with. They also discussed how their experiences had shaped their resilience and adaptability. Finally, in terms of future development, participants spoke about the importance of developing inclusive services for trans people.

4.7.1 Subordinate theme: Post-traumatic growth

All participants in this study spoke about experiencing some positive psychological changes as a result of the adversity and challenges they had experienced. Experiencing discrimination on a regular basis represented significant challenges to the adaptive resources of the individual, but also to how they understood the world and their place in it. The interpretation participants ascribed to post-traumatic growth was that they did not return the same life before the traumatic experience, as for them, traumatic experiences encompassed much of their lives. Participants spoke about their

experiences having contributed to a deeply meaningful personal process of change for them and having altered how they thought about and related to the world. The findings of this study indicate that taking ownership, testing and confronting, having confidence, challenging the idea of being 'a victim', advocacy and having goals were strategies that allowed participants to live with their experiences, but also to take some meaning from them.

Taking ownership

Participants described the thought process involved in wanting to take back control of their lives following trauma. Many felt it was within their control to shape their lives. Taking ownership for them was about choosing to be proactive and take responsibility for their own development. Rather than ruminating on their difficult experiences and all it had taken from them, participants described a process whereby they actively went out to improve their own quality of life.

"I can make things better than they are now, I think it's within my control to do so, so even though things are not as good as they can be now, I think I can make them even better." (Sarah, p.33)

"I would normally be the sort of person who waits for things to happen, rather than goes out and does them…whereas now I…I force myself to do things, otherwise I'll just get stuck in a rut and nothing will happen…" (Jennifer, p.10)

"Cos to me as well there's no point in being upset about something if you can't do something to change it and if you're upset and you can do something to change then do it!" (Jamie, p.20)

Testing

Some individuals described coming to a place of understanding that they needed to test and push themselves in order to move on. Two participants described having previously felt marginalised by society because of their gender identity. However, they also spoke about isolating themselves from the public as a means by which they could feel safe. One of the ways they felt they could break this cycle was to

deliberately put themselves in similar scenarios to those in which they had experienced discrimination and/or hate incidents before, in order to break the sense of anticipatory fear of attack or rejection. One participant explained that for her, it meant going out in public and accepting the possibility of 'not passing', but that not every experience of being in public meant she was going to be attacked. Similarly, a second participant explained that she did not let past experiences of discrimination in accessing employment deter her from continuing to push herself in applying for work.

"If I feel like I've been hard done by or been fucked over…for me, for my own health, sometimes for me it's putting on my boots, putting on my jackets and going into town and being seen, putting myself in the position of danger, of somebody could clock me, somebody probably already has clocked me but it's proving to myself that it's not the end of the world." (Siofra, p.16)

"So that's the strength, no matter how many times you've been kicked constantly about giving your birth cert, you still have to go and get a job, and you know you still have to get a job and you have to work at that job…you have to say that's seven weeks work, I'm gonna treat that now as if it was my own." (Megan, p.17)

Having confidence

As discussed previously, some participants reflected on whether presenting as very anxious in public, or trying their hardest to conform or pass in society, drew more attention to them or left them open to an increased likelihood of victimisation. Some spoke about the connection between feeling paranoid about their appearance and how that presents in their body language. Some spoke, in the same vein, about realising that having confidence in oneself can be a significant contributor to passing. Two participants described the process of gaining the confidence to out as themselves in public. For them it meant holding their head high, aware that any abuse could be easily met. Embracing their self-worth not only strengthened a positive sense of self, but also allowed them to stand up for themselves when others would not. They described this as having a knock-on effect as, as they became more self-assured in themselves and in their appearance, they didn't feel anxiety or anticipatory fear to the same extent.

"But as I say, it's a confidence thing as well, you're walking along, and you're not showing any signs of who, what your past was. It's like you're completely, it's like being an actor, you have to try, you have to get into a groove to match the physical body movement of what's in your head…" (Joanne, p.24)

"I don't worry about it, I don't think about it, I used to fret about it…but now I'm quite confident, I do my own thing, either people don't realise or people don't care…I think confidence is the key as well you know…all these things you just build up, the confidence and experience I suppose you know… and you just chalk it down, you do it once or twice and it's just not a big deal anymore…" (Jennifer, p.9)

Challenging/ refusing to become a victim

For some post-traumatic growth meant progressing beyond feeling like a victim, although for most this was a role from which they felt they couldn't escape. As mentioned previously, participants had described feeling helpless and powerless to control what was happening to them. This led to them becoming mired in feelings of victimisation, viewing targeted hostility as happening to them, causing them to feel ineffective and overwhelmed. Challenging their own victim status, meant acknowledging the difficulties they had experienced and not focusing on assigning blame for conditions that were ultimately outside of their control. For two participants, this meant not doing things that would have reinforced their victim status, such as refusing to accept circumstances they would previously have accepted and not making deliberate changes to who they were just in order to fit in.

"At that age I just accepted it, but today I wouldn't…today I wouldn't even ask I would just go and use the bloody changing room and if someone had a problem with it I wouldn't back down." (Jennifer, p.3)

"I have this mindset that I'm not going to change my life to protect myself…I'm not going to change who I am to make myself safer…so it was less of like, oh my gosh people are gonna target me, well how can I hide…and I was like I'm done hiding." (Jamie, p.7)

Having goals

Having clear goals and aspirations gave participants a lot of hope for the future. Some found that by visualising a future goal it gave them a sense of direction and a focus beyond the traumatic experiences. Visualisations gave them focus and motivation for how they wanted their life to be in the future.

"It's important to see them clearly, it's important to see a pathway towards them…rather than talking about them as some sort of aspiration…so I can see things rather than just so even if there's a lot of anxiety involved, I do need to try and bring them into the present." (Sarah, p.46)

Another way in which participants used goal-setting to help them focus beyond the trauma was advocating for their own rights and the rights of other trans people. They spoke about using their experiences to help others in similar situations.

"…I mean I'm at the point now where I have a couple of eggs and fledglings…which are new trans people…and it's quite interesting to see them go through some of the things that I went through." (Siofra, p.16)

"I'm also the type of person who my goal in life has always been, all the bad things that I've gone through...I'm gonna use them to be able to help people…like I have a lot of experiences that I can share with other people who might be going through something similar and let them know there are not alone and things like that…I've always found myself making changes or thinking changing how I'm thinking so that I can be a better role model for people…" (Jamie, p.18)

4.7.2 Subordinate theme: Meaning of resilience to the individual

Participants universally suggested that trans people in particular, are more adept than others at bouncing back from adversity. They suggested that their own personal resilience formed as a result of a combination of innate traits and learning from experience, but there was widespread agreement amongst participants that it was possible to increase personal resilience and learn to handle stressors better.

"I suppose I drew on what inner strength I have…and I had to learn to be resilient and look after my own mental health and know exactly what I was capable of

doing and what I couldn't push myself to do…so I had to do that, I suppose with experience and with hindsight." (Joanne, p.17)

For all participants, their own personal resiliency depended on the resources they had available to be able to deal with stressful situations. Resilience was for most a continuously developing individual process, rather than simply a trait. Personal resilience was about using acceptance and acknowledging their own negative emotions or thoughts. All universally agreed that resilience did not meaning keeping optimistic in most or all situations. Participants felt that over time they had developed coping techniques that allowed them to effectively deal with stressful situations as they arose. It also gave them the ability to manage strong impulses and feelings.

"I think it means acknowledging what you went through sucked…and not trying to brush it off, and be like no everything is fine, I'm ok, no…resilience is acknowledging that it's ok not to be ok and like learning how to not be ok but still cope at the same time…and learning that coping is ok, sometimes coping is the best you can do and there are some situations where like the best you can do, is the best you can do and you have to stop putting expectations on yourself because it's gonna take different amounts of time to heal from things, whether it be from you personally experiencing different things in different situations or your experience of a situation versus someone else's experience of the same situation…like you can't place expectations on yourself in either situation." (Jamie, p.16)

For all participants, being resilient also meant drawing on their own mettle and internal strength. Interestingly, each used the adjective 'stubborn' or variations thereof to describe themselves at one or more points throughout their interviews.

"My resolve, no matter how many times I get knocked down I still get on with it…I'm just a stubborn cow that needs to work and I'll just keep going I'll keep trying… I know I can deal with whatever is thrown at me, it's just unfortunate that I have to keep doing it…" (Megan, p.24-25)

"I think I'm stubborn, always been, always will be and I think that's my anchor…that's it…if I set my mind on something I will get there, I don't care…whatever it take I will get there and I think I'm resilient, I can take a lot and my weakness is that I don't let it out…I just sit and take and take and take…but I can take a lot, and I don't give up…ever! So I think that's my support…" (Mark, p.11)

One of the specific contributors to resilience was perceived to be the ability to make realistic plans and be capable of taking the steps necessary to follow through with them**.** For participants, this sense of self-efficacy included the belief in one's ability to organise and accomplish the courses of action required to achieve their necessary and desired goals.

"I know that things can get better to if you just hang in there so the fact that I did has given me help to develop some resilience I suppose…I would feel like hiding myself away, I would feel like not talking to others but it wouldn't actually stop me attending a training session, I would still be there and I would still benefit from being there. It would be better if I felt better about myself but I would still have the experience of being there" (Sarah, p.24)

"I know who I am…I know where I want to be…because I need to…it's not because I want it…because otherwise I would be dead, because I don't want to be here if I can't be who I am…I would not be here today if I did not go down the path…" (Mark, p.14)

Participants were also very aware that their own personal resilience was not an infinite resource. They recognised that there were times when they felt more or less resilient and the times when they felt less resilient, they needed to give themselves the time to build it back up again.

"But that kind of resilience takes energy, and it erodes over time, unless it's given an opportunity to build itself back up, to actually pick itself back up off the mat…I mean your legs will eventually go out from under you…" (Siofra, p.15)

One participant reported her personal resilience came from refusing to change who she was and how she identified, which is similar to the previous discussion of refusing to conform to the victim role. She reported that she had learned over time that when she would actively try to hide herself or blend into social norms, her feelings of guilt and shame actively took away from her resilience.

"There are certain things where I would be more resilient but it's usually like when I take a stand and I'm like no I'm not gonna change…whereas I don't feel so resilient when I'm hiding for my safety or for…lack of conflict or for…whatever the

reason I don't feel resilient, I feel like I'm really disappointed in myself when I do things like that because it lends itself to." (Jamie, p.18)

Others spoke about how their resilience stemmed from their experiences and the multiple challenges they had faced. As a trans person, their resilience was never limited to just one traumatic experience. Most had contended with poor social support, relationship break-downs, loss, financial issues and the process of transition which was in itself a traumatising process. Some felt that by virtue of being a trans individual meant you had to be resilient.

"You are either resilient or you're dead…I think resilience…I think you can learn to see things from a different point of view, I think you can learn to see two sides of things, I think you can learn that if you think you are on a one way path and you can't stop somewhere…every tunnel has at least two ends you know? At least two ends, so you can't stop looking for that…" (Mark, p.16)

"I mean I've had to be resilient, it's not just the gender issue that's been there, there's been other things as well, marriage break-up, the loss of (previous partner) which was traumatic…" (Joanne, p.21)

"So that experience, from learning those things, from being bashed about, and I understand that those things are in and of themselves - traumatizing…I think they toughened me up enough that when I finally couldn't maintain the mask anymore, I was at least able to survive…I had already been lifted in terms of my resilience and toughness with regards to those things so they really just…the hits just kept coming and I just kept taking them…" (Siofra, p.18-19)

Some saw their personal resilience as a double-edged sword, as although they had become more adaptable by virtue of having had experiences of transphobic discrimination, they also reflected on if they hadn't had those experiences would they have needed to be as resilient.

"I think it's made me stronger to be honest…more determined, more ballshy, more stubborn… so in a way it's been a good thing, in another way, it shouldn't be there in the first place…?" (Jennifer, p.7)

4.7.3 Subordinate theme: Developing trans-inclusive services

As discussed earlier, participants reported significant barriers to accessing health services. Participants felt that the current model of transgender specific clinical care and the healthcare delivery system did not meet their needs, with many reporting experiencing discrimination and secondary victimisation while engaging with services. Participants felt there is a need for trans-specific healthcare that adheres to a more patient-centred, gender affirming model of transgender clinical care. Participants also stressed the need for further research and advocacy in these settings, and the importance of further education and training for healthcare professionals about the needs of transgender patients.

Many felt that the current referral pathway for treatment was still unclear, citing confusion as to who to turn to first.

"I think what would be good to get out there would be some sort of clearly defined path for people who are experiencing trans issues…like who do you talk to first? but definitely to have a clear path…there's the paperwork, stuff like electrolysis…like all these things that you need to do but you just don't know where to start of who to talk to…there needs to be some sort of path there I think…" (Jennifer, p.11)

Finally, many felt that clinicians needed a further understanding of the various needs of trans people, with many citing that further training and education for clinicians was vital to developing their working relationships with trans patients and improving access to healthcare.

"I think it also helps that anybody who's involved with mental health or like going to counseling kind of understand more about the way I think about myself or see myself and gets helps me be more comfortable with who I am, understand myself more…" (Jamie, p.1)

"They're just not educated about trans issues…they don't want to talk about it…like I didn't even go for anything trans related…" (Jamie, p.21)

"There was a little bit of education needed at the start of my counselling…we had a couple of awkward moments shall we say…? A lot of GPs have no concept or understanding" (Jennifer, p.10)

CHAPTER FIVE: DISCUSSION

5.1 Chapter introduction

The present study sought to explore how trans people describe and understand their experiences of transphobic discrimination and/or hate crime, and how they understand their coping and resilience following their experiences. This chapter will recapitulate each superordinate theme identified, and present a discussion of the significance of these findings for our understanding of coping and resilience in the trans community and beyond. , The implications of the research findings for practice, education, policy and future research will be examined. Finally, the strengths and limitations of the current study will be addressed, along with the researcher's critical reflections on the research process.

5.2 Summary of findings

Participants addressed their experiences of coping and resilience under three key themes. 'Psychological impact of experiences', the first superordinate theme, described the effects of experiences of transphobic discrimination at an emotional, physical and cognitive level. 'Coping', the second superordinate theme, included participants' descriptions of how they managed following these experiences, whether through drawing on internal coping mechanisms, or seeking external support. Participants described both positive and negative experiences of seeking external support.

The final superordinate theme, 'Resilience' described how participants moved on from these experiences of hostility and the factors that shaped their resilience. The majority of participants described experiencing some form of post-traumatic growth following their experiences. Interviewees' feedback regarding developing appropriate and supportive services for trans people will be discussed in the context of implications for practice.

5.3 Psychological impact of experiences

All participants described a significant traumatic response to their respective experiences of discrimination and/or hate crime, which affected them at an emotional, cognitive and behavioural level. These findings are transferable in that they concurred with those of previous research in detailing the significant impact of hate crime victimisation and discrimination on minority groups. These findings are consistent with both the assumptions of the minority stress model (Meyer, 2003), and the subsequent gender minority stress model (Testa et al., 2015). Both models propose that members of the LGBT community, particularly trans individuals (in the case of the GMS model), are subject to chronic psychological stress due to their experiences of stigmatisation and discrimination in society. The GMS model in particular, stresses that the external stressors of discrimination and pervasive harassment are related to elevated symptoms of psychological distress, including suicidal ideation, anxiety, and depression. One of the most significant emotional responses, described by participants in this study, was increased levels of fear and anxiety following incidents of hostility. These feelings of fear varied from an increase in anxiety about being out in public, or going anywhere at nighttime, to hypervigilance about being attacked, and even - in the case of one participant - post-trauma distress manifesting as flashbacks, which caused significant distress. These narratives are consistent with the GMS model, which proposes that experiences of transphobic discrimination may promote and reinforce stigma hypervigilance or increased fear of encountering future discrimination (Testa et al., 2015). These findings are also consistent with research regarding the impacts of hate crime in other minority groups, which suggest the psychological sequelae can manifest as: anxiety and panic, hypervigilance around repeat victimisation, greater perceived vulnerability, decreased trust in the benevolence of others and a lower sense of autonomy (Herek et al., 1999; 1997; Barnes & Ephross, 1994; Szymanski, 2005).

Burnout and low mood were common emotional responses in the face of pervasive discrimination, in the current study. For many participants, the consequences of living with constant stress and fear of victimisation led to them experiencing ‘burnout’. Repeated incidents of discrimination re-triggered previous feelings of anxiety and low mood. Across all participants, feelings of despair and low mood were common responses to iterated experiences of transphobic discrimination at many levels and

over time. Such responses also support the explanatory power of the GMS model, as well as alternative research linking elevated levels of depression to experiences of hate crime or pervasive discrimination in trans individuals (Nemoto, Bödeker & Iwamoto, 2011; Mizock & Mueser, 2014, Clements-Nolle et al., 2006).

Every participant described feeling personally victimised in response to their experiences of transphobic discrimination and/or hate crime, and all felt the motive behind the incidents was related to their gender identity and/or expression. For some, personal victimisation manifested as feeling excluded and marginalised from various different social groups. For others, feeling victimised manifested as feeling deliberately neglected and diminished by others or by a system. A significant emotional impact of this victimisation was feelings of helplessness and powerlessness and unable to challenge feeling targeted. This echoed the findings of previous research which highlighted that transphobic stigma and discrimination is linked to feelings of shame and powerlessness (Spicer, 2010). These feelings of powerlessness have also been described by other studies investigating the effects of hate crime on victims (Dzelme, 2008; Iganski, 2008; 2001; D'Augelli & Grossmann, 2001; Herek et al., 1997). As a person's fundamental characteristics are something they cannot change, such as their gender identity, those in minority groups are at an increased risk of repeat victimisation. Therefore victims of hate crime can often feel powerless in the face of repeat discrimination and that there is little they can do to manage or prevent the risk of future victimisation (European Union Agency, 2012). Many of the above authors suggest the effects of hate crime are more detrimental to mental health and wellbeing and compared to other types of crime victimisation. Although it is beyond the scope of the findings of the current study to argue whether these effects were more detrimental to the individual than they would have been had the incident not involved a bias motive, it is certain that participants' narratives were consistent with the aforementioned literature.

As every participant described some form of negative self-questioning and internal examination following their experiences, it was clear the impact of this self-questioning left the individual feeling intense self-doubt, even to the point where they questioned the choices that had led them to that incident. The self-checking participants described in the current study is akin to the internalised transphobia

described by the GMS model which emphasises that trans individuals may internalise society's negative beliefs and assumptions about trans people into their self-concept. Internalised transphobia and stigma has been linked with negative self-appraisals, which in turn can lead to the development of adverse mental health outcomes, such as depression and anxiety (Meyer, 2015; Testa et al., 2012; Morrow, 2004).

Every participant in this study discussed contemplating suicide more than once, or had acted upon suicidal thoughts following their experiences. This is consistent with findings from other research, which state that there is an increased risk of suicide among trans individuals who have been victimised, harassed and rejected (Grant et al., 2010; Nuttbrock et al., 2010; Grossman & D'Augelli, 2007). It is also consistent with auxiliary reports that transphobia is a key contributor to elevated rates of mental health problems and suicidal ideation among trans individuals (Testa et al., 2015; Bockting et al., 2013; Mizock & Mueser, 2014). Thus, for the trans individuals in the current study, it appeared that their experiences of hate crime and discriminatory incidents, as well as the increased risk of repeat victimisation lead to the development of various forms of psychological distress, all of which is consistent with previous literature. These findings confirm international patterns with respect to the emotional and psychological impacts of transphobic hate crime and discrimination, which are apparent among the trans community in Ireland.

5.4 Coping

5.4.1 Internal coping strategies

The current study found that a mixture of coping methods were used, and that the coping skills and strategies deployed changed over time, depending on participants' circumstances. The coping mechanisms described were classified into three categories: problem-focused coping, emotion-focused coping and appraisal-focused coping strategies. The significance of these findings shows that participants describe coping strategies as a means of buffering the effect of the stressors, so that the negative affect and psychological distress described above can be reduced, or the future likelihood of the same reduced in future. The coping strategies outlined by participants reflect the Lazarus and Folkman (1984) model of coping. This model

focuses primarily on problem-focused and emotion-focused coping, thus this research supports the view that the model is not fully comprehensive and the argument made by authors such as Pearlin & Schooler (1978), Folkman, Lazarus, Gruen & Delongis (1986) and Endler & Parker (1990) that appraisal-focused coping is as valid and significant as problem-focused and emotion-focused coping for alleviating distress.

The coping literature related to trans individuals is sparse and primarily focuses on coping with the stress experienced during gender transition. Within this body of work, coping, via collective self-esteem, has been found to alleviate psychological distress related to transitioning gender identity (Sanchez & Vilain, 2009). The findings of the current study are significant in that coping is applied to a new context and to one that addresses hostility that is experienced throughout the life course, rather than during transition.

Participants in this study described problem-focused coping strategies, which conformed to the patterns of directly addressing the cause of the distress in order to reduce it (Lazarus & Folkman, 1984). Participants spoke about utilising practical methods such as conforming to societal norms, avoidance and self-checking behaviours as mechanisms to help them feel safer. For the trans people in this study, they had little capacity to prevent hostility by controlling factors external to themselves. Participants described trying to mask what they felt were obvious features to try and blend in and 'pass in society'. Participants described engaging in self-checking or safety behaviours such as checking their make-up before going out to help reduce their anxiety and help them feel more confident about 'passing in public'. All these methods were mechanisms that allowed participants a greater perceived control over their stressor. Previous studies have found that transgender people can engage in coping mechanisms such as changing/concealing their self-presentation and appearance for different social purposes such as self-protection, or to promote passing, due to fear of future victimisation (Bockting et al., 2013; Cashore & Tuason, 2009; Levitt & Hiestand, 2004). Similarly, the coping strategies described by participants in this study correlate with Dzelme's (2008) discussion of coping strategies used by minority groups in response to hate crime victimisation. Dzelme argued that in attempts to avoid repeat victimisation, the individual will try to build a safety barrier around them, which can result in the person making deliberate changes

to their appearance and behaviours to avoid being singled out. Other problem-focused coping mechanisms cited by Dzelme include: the person withdrawing and deliberately isolating themselves for fear of repeat attack. This concurs with the findings of this study, in which some participants described deliberately isolating themselves from others as the only method by which they could manage their distress.

Although the problem-focused coping described by participants in this study sought to manage the stressor -in the sense that they sought to reduce the likelihood of experiencing hostility. However, the behaviours they cite are centred on the trans person themselves rather than on the person who engages in hostility towards them or the cultures which 'give permission' (Perry, 2012) to people to engage in such hostility. As problem-focused coping has been defined as targeting the source of the stressor (Carroll, 2013), it is worth questioning whether the problem-focus coping described by participants is truly effective, as it appears to be misdirecting the targeting the source of the stressor. Pascoe and Smart-Richman (2009) said that one of the pre-conditions of an effective coping strategy is a clear understanding of the stressor itself. If trans people are misrepresenting the source of the stress by blaming themselves for what is a social problem, or the offender's problem, does this impede their development of effective problem-oriented strategies? In these circumstances, there a possibility that previous research findings regarding the effectiveness of problem-oriented coping strategies does not hold in the same way for transphobic hostility. As discussed previously, alternatives to problem-focused coping (i.e., emotion-focused coping) have been described as better suited for stressors that are perceived to be beyond the control of the individual (e.g., victims of hate crime (Ahluwalia & Pellettiere, 2010) or people who are routinely stigmatised because of their identity (Miller & Kaiser, 2001)).

Participants described trying to reduce the negative emotional responses they experienced as a result of the stress and trauma, such as embarrassment, fear, anxiety, depression, and frustration. The emotion-focused strategies they described included avoidance, distancing themselves emotionally from others, and suppressing or compartmentalising their distressing feelings. These strategies are consistent with emotion-focused strategies, which are defined as aiming to regulate one's emotional responses when one cannot control or eliminate the source of the stress. Studies have

illustrated that these strategies can include, but are not limited to: distancing, avoiding, selective attention, blaming, minimising, wishful thinking, venting emotions, seeking social support, exercising, and acceptance (self-acceptance, or acceptance of situation) and positive reappraisal (Carver & Vargas, 2011; Ben-Zur, 2009; Folkman & Lazarus, 1988). It appears that there is little difference between the way emotion-focused strategies normally manifest and how they manifest for the trans community when comparing the findings of this study with those of the aforementioned literature. Some studies have suggested that emotion-focused coping is less effective at dealing with stress related to discrimination (Pascoe & Smart-Richman, 2009; Noh & Kaspar, 2003). However, given the limitations that trans people experience in utilising problem-focused strategies, we may need to reassess the value of emotion-focused strategies in relation to coping with transphobic hostility.

Participants also described using appraisal-based coping methods, which were directed towards cognitive restructuring whereby they challenged their own assumptions and re-evaluated the way they thought about the stressor/scenario. All described some of self-reflection as an invaluable means of managing the trauma; whether this was reflecting on the positives and/or looking at the bigger picture. Those who described reflection on positives engaged in reframing how they thought about their experiences to focus on more positive aspects of their lives, and come to a greater understanding of what life meant to them. This is consistent with findings of the Supporting LGBT Lives study (Mayock et al., 2009), where participants described using cognitive reframing as a positive coping strategy in the context of alleviating distress caused by discrimination and violence. Similarly, trans participants in the Budge et al., (2013) study described using specific appraisal-focused coping mechanisms to manage transition stress such as positive reframing, feeling a sense of responsibility to others, being true to oneself, and letting go and acceptance. The effectiveness of appraisal-focused strategies has been commented on in LGB individuals managing stigma-related experiences (Denton, Rostosky, & Danner, 2014). In addition, appraisal-focused coping may be particularly useful (in place of, or in combination with) problem-focused coping in the context of pervasive or chronic stressors because there may be an inability to use active coping strategies to fix the stressor itself (Lepore & Greenberg, 2002). This is particularly relevant to the trans

community considering the limited control they have in addressing the core causes of their stress.

With regards to coping, these findings are significant in that they convey that members of the trans community in Ireland utilise coping strategies that are documented internationally as responses to not only transphobic victimisation, but also hate crime victimisation more generally. Secondly, they indicate that psychological concepts can be applied to the interpretation of these behaviours, which have not previously been applied in research on transphobic hostility. The use of these conceptualisations of coping adapted from the Lazarus and Folkman model (1984), advance our understanding of the coping behaviours with regards to transphobic hostility, as it demonstrates that trans people use a combination of problem-focused, emotion-focused and appraisal-focused strategies in order to alleviate psychological distress. Pascoe and Smart-Richman's systematic review (2009) presents supported conclusions regarding the effectiveness of the different approaches to coping (problem, emotion, active, passive), and we can also use this application to help interpret the likely psychological impact of the various coping mechanisms described by the trans community. This information could be valuable to psychologists and peer support groups facilitators who support trans people who are engaged in making choices about coping responses. Although Pascoe and Smart-Richman suggest *"not all coping behaviours are equally successful"*, and that active or problem-focused coping appear to be the most effective with regards to managing the effects of discrimination, they also accept that there may be variations by ethnicity, culture and gender.

5.4.2 Experiences of seeking external support

The findings of this study also indicated that participants felt a significant contributor to, and facilitator of their coping was building a connection with one or more supportive communities. Whether this was from partners, friends or family members, all participants relayed that at different points throughout their lives they felt the need to open up and seek support from others. Linking in with community-focused organisations was also something that some participants found to be a positive experience, as these communities helped encourage them when they felt overwhelmed

and less resilient, and also provided information when needed. This is consistent with previous literature which has found that engagement with other trans people and linking with community supports significantly enhances resilience during gender identity development and transition, as it has been associated with feeling less alone (Hughto et al., 2015; Testa et al., 2014; Mizock & Lewis, 2008). The importance of community support groups and social support for managing the effects of stigma has been stressed in the literature, as imperative emotional support (Trujillo et al., 2017; Bradford et al., 2013; Schrock et al., 2004). Other studies have framed it as when coping with this type of stress, particularly minority stress, feeling connected to and a positive identification with one's social identity group can be beneficial for reducing psychological distress (Bockting et al, 2013). According to the above literature, social support seems to be an effective buffer. However, for trans people this can be difficult to access through the usual channels of family and friends because of the stigmatisation of gender non-conformity, which can lead to alienation from family and general social marginalisation. In these circumstances, other studies have cited the value and potential of peer support groups as an effective means of managing the psychological distress associated with transphobic hostility (Singh et al., 2011).

However, in addition to describing the positive potential of external support, participants also described negative experiences while seeking support from state agencies such as the health service and mental health services. Participants described feeling that they were being discriminated against at the highest level, and that they were trying to fit into a system that didn't recognise them or was unwilling to cater to their needs. The majority of participants reported feeling that the structure of certain systems, such as the health system, completely marginalised them from society. Particularly with regards to the health service, most participants described their experiences of engaging with the health system as predominantly negative. Even while engaging with trans-specific services, participants felt their interactions with staff and the lack of inclusivity in services was damaging to their psychological wellbeing. The literature has suggested that these services can potentially be an important resource in coping (McCann & Sharek, 2014a; 2014b); however state agencies tend to be institutionally cisnormative and therefore are rarely an aid to coping and resilience (LeBreton, 2013; Knight, Shoveller, Carson, & Contreras-Whitney, 2014).

Trans people report experiences of discrimination in health services internationally (Grant et al., 2010). Reports of trans people's gender identities being pathologised, invalidated or erased during interactions with healthcare service providers are common within the literature (Ellis et al., 2015; McCann, 2015; Benson, 2013; Kidd et al., 2011). It has been suggested these experiences can, understandably, lead trans individuals to conceal their gender identity when attending health or mental health services, develop considerable mistrust towards mental service providers, and in some cases cause them to disengage entirely from services (Newcomb & Mustanski, 2010, McCann, 2015; Benson, 2013). This is concurrent with experiences described by participants in the current study, as many described negative experiences of seeking care in the health service, which in addition to anticipatory fears around rejection, made them less likely to seek help in future. Most felt their negative experiences precipitated a reduction in trust in the system. These findings provide support to the growing body of evidence of secondary traumatisation or experiences of retraumatisation while engaging with state services. Many participants described anticipating secondary victimisation within the health system or justice system and therefore decided against linking in with services

Unpredictable, and sometimes negative, responses from practitioners to trans people seeking health care in an Irish context have also been documented by McCann and Sharek (2014). Similarly, in the LGBTIreland report, Higgins et al. (2016), notes that a significant number of respondents reported barriers to accessing care related to a lack of training and awareness of behalf of health care professionals, the lack of continuity of care and carer; the lack of quality care; poor follow-up; and the short-term nature of the help offered. Comparable with participants with in the current study, respondents to the LGBTIreland study reported that negative experiences of interacting with health care professionals discouraged them from engaging in future services. These included experiences of homophobia, difficulties in building rapport with mental health professionals, and challenges in establishing a therapeutic relationship. This is concurrent with other studies examining LGBT perceptions of health and mental health service providers which have indicated a gap in adequate training and education on LGBT-specific issues (McCann & Sharek, 2014a; 2014b; Ellis et al., 2015; Taylor, 2013; Grant et al., 2010). Some studies have indicated that

trans and LGB individuals have reported instances where they feel the need to educate health care professionals on LGBT-specific issues in order to access appropriate care (McNeil et al., 2013; Grant et al., 2010).

The findings of the current study concur with previous research, which finds that trans people have experienced direct discrimination while seeking care in the health system. This has included being rejected for accessing health care on the basis of being trans or being made feel uncomfortable while seeking care (Cruz 2014). Furthermore, when people do access services, they can experience prejudice on the part of some health care providers, which causes unnecessary hardship (Jalali & Sauer 2015; Roberts & Fantz 2014). Trans people and other minority groups have reported that the lack of understanding, and even blame, from those who were supposed to support them re-opens old emotional wounds, as well as reinforcing feelings of anxious anticipation of rejection (Testa et al., 2012; Dietz, 2001; Berrill & Herek, 1992). The feedback participants in the current study provided with regards to developing trans-inclusive services will be discussed later in the chapter.

5.5 Resilience

Resilience research in the LGBT population has indicated that individuals can survive and even thrive, in response to the experience of stress and discrimination (Meyer, 2015). All participants in the current study spoke about experiencing some form of post-traumatic growth as a result of the adversity and trauma they had dealt with. Participants spoke of their experiences of coping with hostility having contributed to a deeply meaningful personal process of change for them and having altered how they thought about and related to the world. The findings of this study indicated that taking ownership, testing and confronting, having confidence, challenging the idea of being ‘a victim’, self-advocacy and having goals were strategies that allowed participants not only to live with their experiences, but also to take some meaning from them.

The findings of this research are consistent with a growing body of evidence indicating that trans individuals can experience posttraumatic growth and resilience following trauma, which in turn can buffer the effects of future stressors (Burnes, Dexter, Richmond, Singh & Cherrington, 2016; Singh et al., 2011). Burnes et al.

(2016) reported that their participants described several protective factors that assisted them through these experiences of trauma. Protective factors including having a positive self-perception, hope, and engaging in advocacy for themselves, and for other trans people, promoted their resilience.

The findings of this study reflect Tedeschi and Calhoun's (1996) conceptualisation of post-traumatic growth whereby an individual can experience growth in a number of different ways including: a greater appreciation of life and prioritising more positive, life-affirming goals; warmer, more supportive relationships with others; a greater sense of inner strength; exploring the possibility of new avenues or pathways for one's life; and spiritual development. Post-traumatic growth has also been associated with greater advocacy awareness, increased confidence, independence, and self-efficacy (Burt & Katz, 1987), psychological preparedness for future adversity (Janoff-Bulman, 2004), and increased self-understanding and self-acceptance (Ruini & Vescovelli, 2013; Joseph et al., 2012; Armelli et al., 2001). Or growth may involve smaller changes such as improving relationships and dealing better with stress (Park & Fenster, 2004); improved cognitive and behavioural coping skills and increased personal and social resources such as increased self-reliance (Cadell et al., 2003; Schaefer & Moos, 1998). Comparatively, participants in this study felt taking ownership for them was about choosing to be proactive and taking responsibility for their own development. The dimensions of post-traumatic growth described in this study included, taking ownership, testing and confronting, having confidence, challenging the idea of being 'a victim', self-advocacy, increased self-reliance and having goals. As not every dimension of post-traumatic growth as described in the literature manifested in the context of this study's findings, it is possible that this difference could be due to a focus on the general or LGB population in the previously-discussed literature, as opposed to a focus primarily on trans people.

The findings of Singh et al. (2011), Singh and McKleroy (2011) and Mizock and Mueser (2014), all identify that resilience in response to transphobia is not just comprised of internal learned behaviours, but is also about being able to connect to a wider community that in turn can reflect back to them their strengths when they might not be able to do so for themselves. Participants in this study felt that their resilience manifested through a combination of innate traits and learning from experience, but

there was widespread agreement amongst participants that it is possible to increase personal resilience and learn to handle stressors better. The findings of this study elaborate on how trans people understand their own resilience and where it comes from. Whereas previous research has indicated that resilience is both innate and about connection to others with regards to trans people (Singh et al., 2011; Singh & McKleroy, 2011; Mizock & Mueser, 2014), the current study's findings suggests that trans people describe their resilience as both innate and learned behaviours.

5.6 Strengths and limitations

There are strengths and limitations of this study, which emerged throughout the process of the research, which are discussed below.

5.6.1 Strengths

The current study sought to provide insights into experiences of coping and resilience in trans people in response to discrimination. It gave a voice to trans people to explore how they describe their experiences of discrimination, and how they feel it impacted on them psychologically. A key strength of this study includes addressing a gap in the literature regarding coping and resilience, where only scant attention has been paid previously to the coping resources of trans people in response to transphobic hostility (Singh et al., 2011; Singh & McKleroy, 2011; Mizock & Mueser, 2014). Although prevalence of transphobic hate crime and discrimination are well-documented in the literature, this research provides further evidence to highlight and illustrate the challenges faced by this marginalised population. As important as it is to continue to direct attention towards this issue, there is a noticeable dearth of research on how trans people describe their coping following these experiences and how it affected them psychologically. This study provides a link between the meaning of the experience to the individual and how they compartmentalise it as part of their identity.

Although findings in previous studies have supported the correlation between discrimination and negative affect, the use of IPA in this study facilitated a narrative richness around how participants described their experiences, their coping and resilience. Although IPA tends to be a labour-intensive approach, another approach,

such as thematic or content analysis, would not necessarily have provided the same degree of insight into participants' experiences of transphobic discrimination. Future researchers should consider the benefits of employing IPA for addressing similar research questions.

Finally, a general strength of the study was how it advanced the limited and broadly descriptive literature relevant to the mental wellbeing of this population. There is a significant amount of literature dedicated to the mental health needs of trans people, with plenty of headroom given to prevalence rates of suicidality, chronic depression and substance abuse within the population. However, what is often left out in the literature is the context in which these mental health difficulties can manifest. One could argue this in itself leads to a further stigmatisation of the community as it proposes a correlation between being trans and having mental health difficulties. This study elaborates on the connection between certain experiences of trans people and the psychological sequelae that can develop as a result of those experiences. This has clear implications for policy and practice. In addition, the findings of this study also highlight protective factors for these individuals, a key area that is often overlooked in the literature. Finally, another important feature of this study is that it addresses an under-researched community and has achieved access to a difficult-to-reach community.

5.6.2 Limitations

All research will have some limitations and the current study is no exception. A noticeable limitation was the weighting of gender identity. Specifically, the sample comprised mainly of participants who were women with a trans history, with far fewer men with a trans history and non-binary individuals. The study's sample was diverse in terms of income, geographic region, and background, but less diverse in terms of a gender identity spectrum than it could have been. Some research has suggested that coping strategies can be different in terms of their effectiveness for different genders (Morano, 2010); therefore the weighting of gender identity within this study, makes it difficult to transfer the findings across the gender identity spectrum. However, given the study's use of IPA, which has an idiographic focus, the aim of the research was to explore individual perspectives in the context of their

specific experiences. As such, the findings of this study do not seek to make general claims about the wider trans population, but the findings are certainly transferable. The aim was to try and understand the meaning of individual participants' experiences in their own words, rather than confirming the validity of their accounts.

Another limitation to be considered was the lack of representation of trans individuals under the age of 18 within the sample. Younger trans people are perhaps more vulnerable than adult trans people in certain aspects due to their age (i.e., being under 18), and thus their reliance on their parents or guardians for both support and provision of consent for them to access services (Mayock et al., 2009; Higgins et al., 2016). At the time of this study's methodology design, it was thought that the experience of the younger trans person could be an entirely unique experience to those of adult trans individuals, and warranted its own separate investigative exploration, hence the exclusion of younger trans people from this study's sample.

5.7 Critical reflection

As discussed in the reflective component of the methodology chapter, there were a number of issues and processes I considered crucial to reflect on. Employing reflexivity throughout the research process is increasingly acknowledged as an imperative process for establishing rigour in qualitative research (Darawsheh, 2014; Houghton et al., 2013). By exploring and reflecting on my own personal characteristics, beliefs, assumptions and actions, I was able to determine my own position in relation to the research, and how this might influence the research process

Prior to establishing any research questions, I reflected on my rationale for conducting this research, and what impact this might have on generating questions. I recognised that part of my motivation to conduct this research was due to exposure to news items regarding the significant increase in hate crime against different minority groups, and in particular, the transgender community. This elicited my empathy, as I tried to imagine what these experiences were like and how this would impact on the person in their everyday life. Looking at my own background, I did not have anything to relate these experiences to, which then in turn, brought about my own natural curiosity about being able to understand these experiences from the individual's perspective.

Through reflexivity, I was able to situate myself in relation to the research idea and was able to determine my motivation to conduct the study came from a curious, but empathic perspective. As the research idea developed, I reflected on other aspects of my subjectivity which allowed me to consider my positioning in relation to the research:

a) Being a cisgender woman conducting research about the trans community

b) Conducting research as clinical psychologist in training

c) My position as an employee of the HSE conducting research about access to services, which also seeks to feedback to that body.

These concepts in particular were a focus of my reflections on the ethical and methodological choices that I made during the research process and their impact on the process of data collection and analysis.

a) Prior to commencing data collection, I had been concerned as to whether my position as a cisgender woman conducting research about the trans community would impede any part of the process. I questioned whether trans people would feel able to open up to me, and on an data interpretation level, whether I would be able to fully comprehend participant experiences as I do not have first-hand knowledge of LGBT marginalisation. The numbers I managed to recruit for this study were limited and I have no way of knowing whether my role as a cisgender female played any part in that. With regards to the interpretation process, I considered that because it is a subjective experience, I have to consider more than just my role as a cisgender female as an influencing factor for how I interpreted the data.

b) Early in the project, I questioned how to differentiate between my role as researcher and my role as a psychologist in clinical training, and what impact this duality of roles might have upon the research and my relationship with the trans people I was interviewing. Engaging in in-depth interviews with trans people has challenged my own assumptions about what it is to be a ‘good researcher’. Hense (2015) wrote about her own experience of conducting research in areas that intersect with a professional role where the interviewee may see you in two ways - the researcher and clinician. She wrote that there was little point in trying to completely separate the two roles, as it would be too challenging to transition from the expert and detached researcher to the caring and supportive clinician. I found my own experience

mirrored Hense's. As the interview process prompted discussion of, in some cases, very traumatic events for these participants, it was difficult at times to remain the consummate 'outside observer' as a researcher. However, I realised that aspects of my role as a clinician actually enhanced the interview process. It helped vastly in terms of rapport building with each participant, as I was always cognisant of gently bringing attention to where the participant was at an emotional level. For example, at the beginning, I would make it clear to the participant that it was very natural if they felt nervous, and I would ask them to tell me a little bit about themselves, to break the ice, and to help bring their anxiety down. If I felt the participant was becoming distressed because of what they were discussing, I would monitor their emotional reactions, and asked them whether they would like a break. Finally, after the interview, I would debrief the participant and if needed, provided information on available support services. Having informed myself regarding good practice in researching distressing topics, I adopted protocols advocated by the literature (Draucker, Martsolf, & Poole, 2009; Griffin, Resick, Waldrop, & Mechanic, 2003). From reading the literature I learned that most participants tolerate research on sensitive topics well; research suggests that some find participating in research on sensitive topics to be beneficial for their internal process and that responses that indicate distress do not necessarily imply harm (Draucker et al., 2009; Becker-Blease & Freyd, 2006).

c) Finally, I considered the ethical implications of my position as an employee of the health service, and whether findings regarding that body might produce a conflict of interest, particularly as the feedback indicated a gap in services. I consulted relevant ethical literature, which outlined that gaps in services, or reported criticisms of services need to be conveyed in research, even by a 'insider researcher', as that researcher has an obligation to do so (Caruana, 2015; Kalichman, 2001). Through consulting the literature, and discussing the ethical implications with my supervisors, I became aware that as what emerged from the findings could serve as valuable feedback to the health service and have significant implications for practice, I was obligated as both a researcher and a clinician to provide that feedback. In addition, I will provide a report of these findings to TENI, who have the capacity to utilise the findings to lobby for change in state services and to inform the training which they provide to public sector employees.

5.8 Implications for clinical practice

The findings of this study contribute to the growing body of literature around trans peoples' experiences of discrimination and hate crime. Particularly, the findings of the current study provide much-needed context for clinicians in terms of understanding the impact of this particular type of trauma when working with transgender clients; but also to educate clinicians on trans-specific issues. The findings of this study indicate that although awareness of gender identity and trans-specific health care is developing in Ireland (McCann & Sharek, 2014), competency, understanding and consideration from health care professionals with regards to trans clients are still lacking. The lack of a clear referral pathway, coordinated and accessible services, as well as the experiences of systemic discrimination described by trans participants within the health system, diminished their sense of trust and confidence in the system, as well as decreased the likelihood of them seeking the care or health treatments they might need. It is clear that there is an onus on clinicians and the relevant administrative staff to continue to build the capacity of health care professionals in various disciplines to provide services to trans people and their support systems. Unfortunately, there is a lack of specialist care services for this particular population (McNeil et al., 2013), for example, there are no specialists in Ireland for gender dysphoria in minors, nor are there services specifically within the health service to support the individual who is transitioning, and their immediate network, in terms of adjustment.

For clinicians who are inexperienced in working with trans and gender variant clients, there are a variety of factors to take into consideration with regards to best practice. From the beginning, a paramount component to establishing the therapeutic alliance, is to consistently use the appropriate name and pronouns. Research has indicated that consistent misgendering is psychologically damaging to trans people (McLemore, 2014). Where there is uncertainty regarding correct use of pronouns, or a fear of offending on behalf of the clinician, it is important to ask the client what name/pronouns they prefer or identify with. Trans clients will present to mental health services for a variety of different reasons, and not all are directly related to issues with gender identity. As one of the participants in this study remarked, she felt her therapist was continually trying to bring her back to 'the trans issue', when she

wanted to talk about her loneliness and lack of relationships. Well-intentioned clinicians might make the common mistake of assuming that gender identity is the most significant aspect of their client's presentation. It is important therefore, not to presume their rationale for attending, but to remain open and understanding, the same as with any another other client.

As discussed previously, clinicians, and in particular, psychologists and psychiatrists have traditionally been seen as gate-keepers by the trans community. This is, in itself, a barrier for trans people accessing health care. The importance of acknowledging the differences in the therapeutic dyad with regards to trans clients has been documented in the literature (Chang & Singh, 2016; Mizock & Lundquist, 2016). If a trans client feels that access to specific healthcare is determined by their presentation as functioning, compliant and capable, this creates a significant power imbalance in the clinician-client relationship. This is difficult for the process of therapy, as it prevents a truly meaningful and trusting relationship to develop. Unfortunately, the gate-keeper role is still present in Ireland, as it remains a prerequisite for trans individuals to be assessed by psychiatry/ psychology in order to gain access to medical treatments such as gender reassignment surgery (HSE, 2016). Consequently, unless an individual is being assessed by psychology for gender dysphoria and appropriateness for access to medical interventions, it is crucial for clinicians working with trans clients for anything else, to clearly and explicitly explain to their clients that their current access to healthcare is not contingent on the therapeutic process.

5.8.1 Coping and resilience

For trans clients who have experienced pervasive discrimination and trauma and are seeking help in managing the impact of trauma, it is as important to establish a safe, secure base for disclosure, the same with any other trauma survivor. It is not the task of the clinician to pursue discussion of the client's gender identity and expression and how this might link to their trauma experiences, but for the client to disclose as the alliance strengthens (Mascis, 2011). However, if a client discloses experiences of transphobic abuse, and this becomes a focus of therapy, it is essential to carefully explore with them what their understanding and beliefs are about the relationship between their gender identity and their experiences of discrimination. As the literature

base suggests, supported by the findings in the current study, a significant proportion of trans people have experienced, and will experience transphobic discrimination. The trauma of pervasive discrimination and incidents of abuse throughout the lifespan can cumulatively influence how these individuals form meaningful attachments with others; and it can also negatively impact on their relationship with themselves, creating an 'internalised sense of transphobia' (Testa et al., 2012; Morrow 2004).

In the same regard, participants in the current study described using appraisal-focused coping strategies such as acceptance or cognitive reframing as beneficial in terms of their wellbeing. Exploring how a client perceives the relationship between their gender identity and their experience of trauma provides the space for them to reframe what they believe or how they might think about their experiences. It also conveys the understanding to them that the root of the abuse or discrimination does not lie with them and how they identify. This is particular relevant given this study's findings about the particular way that problem-focused coping strategies manifest and the manner in which they seem to focus on the person's identity and expression as requiring management as the only means of reducing the stressor. Using these affirmative approaches in therapy encourages resilience and empowerment in transgender clients (Mizock & Lewis, 2008). Therefore, it is important for all healthcare professionals to present as understanding, affirming, non-judgmental and respectful of trans clients who engage with them. Also considering the current study's findings, in addition to the previous literature regarding resilience in trans individuals, it is important for clinicians to have an integrated trauma and resilience framework when working with trans people who experience transphobic discrimination, as this will promote further development of transgender resilience in navigating future experiences of discrimination within trans clients (Burnes et al., 2016; Richmond, Burnes, Singh, & Ferrera, 2016).

5.9 Implications for education

Professional development in a variety of disciplines, may include some education on working with the LGBT community, but rarely is there specific education provided around trans clients (McCann, 2014; Benson, 2013; Carroll, Gilroy, & Ryan, 2002). This leaves most clinicians without the necessary knowledge or skills to work with

this population. It also limits the trans client, as more often than not they feel they need to hide their gender identity, or they are put in a position where they have to educate the clinician on trans-related issues, as evidenced by the findings in the current study.

It is vital that clinicians in all disciplines become familiar with trans experiences and issues, the same as with any minority population, as it is only through this awareness that they can become culturally competent and sensitive in providing the appropriate care (McCann, 2014; Richmond, Burnes & Carroll, 2012). This professional development is fundamental to the effective assessment, diagnosis and treatment of trans health and/or mental health issues. This could be achieved by providing workshops on trans experiences to a variety of healthcare professional education programmes. Benson (2013) argued that because diversity and individual differences are considered to be a core component of mental health professional education, including education on trans-related experiences would afford better-informed and aware therapists. Similarly, existing health care professionals should continue to develop their awareness through continuing education, workshops, and outreach presentations from services such as TENI.

5.10 Implications for policy

In the 'Being Trans in the European Union' report (FRA, 2014), Ireland was reported to have the second highest prevalence (13%) of hate crime in the EU, in the year prior to publication. As discussed in the introduction, trans people are not explicitly protected in Equality legislation in Ireland and are not covered in the Prohibition of Incitement to Hatred Act 1989. The current lack of hate crime legislation in Ireland acts as a reinforcement of the continuation of discrimination and marginalisation of this community. Even with the provision of the Gender Recognition Act in 2015, it is clear from the findings of this study that it has not ended all incidents of transphobic hate crime or discrimination. Schweppe, Haynes and Carr (2014) argued that the current Irish legislation does not protect minority groups from hate crime, and that the necessity for introducing hate crime legislation was escalating. The findings of the current study, concurrent with the literature base on the negative psychological effects of hate crime and pervasive discrimination, would support the argument for the

introduction of hate crime legislation. Introducing this legislation will recognise the significance and value of trans members of Irish society, and convey the message that they are equal to every other member of Irish society (TENI, 2014). Richmond et al., (2012) reported that improved access to health care and the introduction of laws that prohibit discrimination are factors that will promote a more positive environment for trans clients. From a clinical perspective, clinicians and healthcare services can play a role in this process by advocating for the rights of trans individuals with policy makers, as well as encouraging autonomy and advocacy in their clients. They can also affiliate their support with advocacy movements and NGOs who are advocating for change.

5.11 Implications for future research

There are many opportunities for further research emanating from this research. Particularly with regards to stigma and discrimination, it is important to redirect the focus of research activity away from simple correlational research on the prevalence of mental health issues in the trans community, and aim towards examining the influence of stigma and discrimination as factors in the development of mental health difficulties within the community. It is important to develop and initiate a 'trans-positive' approach to research, that does not reinforce the already existing stigma experienced by this group (Lev, 2004). A trans-positive approach could include a focus on the sources of stress that are located in cultural prejudice and cisnormativity rather than focusing on gender non-conformity as the problem.

The use of IPA in the current study, allowed for rich and in-depth data on participants' perspective on their own experiences. Despite the small sample, the richness of findings indicate that there is value in further research using this methodology to explore the voices and perspectives of trans people. Future research could look at both coping and resilience in trans individuals longitudinally, by interviewing them at different stages of their journey. This would certainly make a significant contribution to the literature on the development of resilience and post-traumatic growth over time, as research has indicated that coping strategies in response to trauma can change over time (Scrignaro, Barni, & Magrin, 2011).

As this study's sample comprised mainly of participants who were women with a trans history, with very little representation of men with a trans history and non-binary individuals, future research should consider focusing on having as much representation as possible within their sample. Furthermore, it would be useful to explore sub-groups within the trans community to identify their unique needs and whether there are experiences unique to subgroups. Similarly, future research should consider the lived experiences of younger trans individuals, as there is also a gap in the literature with regards to their experiences of discrimination, coping and resilience.

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APPENDICES

Appendix A: Interview schedule

Setting: Interviews will be scheduled in an agreed location by both the researcher and participant, ideally in participant's homes if they feel comfortable
Interview Time: To suit participants and researcher – ideally carried out on Fridays (researcher research day) ideally two per day if possible – where necessary if possible interviews on Saturdays will be considered
Duration: 30 to 45 minutes per interview

Stage 1 – Introduction and Rapport Development

Explanation of study and goals, signing of consent forms. Describe the process that will occur: this is an exploratory interview and that there are no right or wrong answers, that I am interested in hearing people's opinions on the questions that are asked. A verbal reminder will be given that both: (i) the discussion is being recorded, and (ii) that participants can withdraw their consent to participation at any time. (both of these are highlighted on the consent form). Confidentiality will be repeated here, ensuring participants that any data collected will be anonymised, transcribed and only the researcher and supervisors will read the transcripts.

Exploration of any queries participants have prior to formal commencement of data collection

Stage 2 – Interview Script

- Can you tell me about yourself?
- Can you tell me how you identify yourself as a person?
- What does identifying as a transgender person mean for you?
- Can you tell me about your own personal experience(s) of transphobic discrimination?
- Can you tell me about your own personal experiences(s) of transphobic hate crime?
- What do you believe was the motive behind these incidents?

- Can you describe how the incident impacted upon you and your identity?
- What kind of supports did you seek following your experience?
- How did you cope following your experience?
- How has discrimination and transphobia impacted on your resilience and ability to cope?
- What does resilience mean to you? What comes to mind about your life experience as a transgender person?
- Over your life as a transgender person, when are times you felt more or less resilient?
- What specifically contributed to this resilience or inhibited this resilience?
- What coping strategies are you using when you feel a need to be resilient to a stress in life?

Stage 3 – Wrap Up and Debrief

Thank the participants for their help.

Offer them the opportunity to review their interview transcript following transcription should they feel the need to.

Provide verbal debrief – anything outstanding / unresolved

Give participants an opportunity to ask any questions or make any comments that they may have.

Tell participants that if any of them feel the need to talk to somebody in the aftermath of the interview there are psychological services available to them on an anonymous and confidential basis (this is stated in the debriefing sheet and the contact details is highlighted within same)

Tell participants that the researcher is willing to meet them again in a week's time if they feel this would be helpful

Appendix B: Participant recruitment poster A

Research Project: Exploring resilience in transgender individuals who have experienced transphobic discrimination and hate crime.

My name is Kristina Cahill and I am currently completing a PhD in Clinical Psychology. My research thesis is looking at exploring the lived experiences of trans people and the wider gender variant community with transphobic discrimination and/or hate crime. I am also looking how to explore where resilience comes from with regards to stigma and discrimination and how these individuals cope following these experiences.

This piece of research aims to contribute to the literature specific to this population by supplying a deeper understanding of transgender individuals' experiences of transphobic discrimination and hate crime as viewed through their eyes .I believe this will be invaluable information to feedback to the community, as well as further research to support the legislation of hate crime in Ireland. This research also has the potential to inform health care systems on how best to support these individuals following these traumatic experiences

If you have suffered abuse because of how you express your gender and would be interested in taking part, or if you have any questions around what taking part would involve, please do not hesitate to contact me and I will arrange to meet with you. All contact will be dealt with on a confidential basis. Your participation would be greatly appreciated with this piece of work.

This research study has received Ethics approval from the Education and Health Sciences Research Ethics Committee. If you have any concerns about this study and wish to contact someone independent you may contact:

Chairman Education and Health Sciences Research Ethics Committee
EHS Faculty Office
University of Limerick Tel
(061) 234101

Email: 14042061@studentmail.ul.ie

Appendix C: Participant recruitment poster B

TRANSPHOBIC DISCRIMINATION AND HATE CRIME

Have you ever suffered abuse and/or discrimination because of your gender identity and/or gender expression?

We are looking to explore the lived experiences of trans people and the wider gender variant community with transphobic discrimination and/or hate crime.

The research involves a 60 minute interview and will take place at a location convenient for you. If you would like to know more, please contact me, Kristina, at 14042061@studentmail.ul.ie

If you know of anyone who might be interested, please share!

University of Limerick
Ollscoil Luimnigh

Transgender Equality Network Ireland

Appendix D: Information sheet and consent form

Transgender Equality Network Ireland

UNIVERSITY of LIMERICK
OLLSCOIL LUIMNIGH

Research Project: Exploring resilience in transgender individuals who have experienced transphobic discrimination and hate crime.

My name is Kristina Cahill and I am currently completing a PhD in Clinical Psychology. My research thesis is looking at exploring the lived experiences of trans people and the wider gender variant community with transphobic discrimination and/or hate crime. I am also looking how to explore where resilience comes from with regards to stigma and discrimination and how these individuals cope following these experiences.

This piece of research aims to contribute to the literature specific to this population by supplying a deeper understanding of transgender individuals' experiences of transphobic discrimination and hate crime as viewed through their eyes .I believe this will be invaluable information to feedback to the community, as well as further research to support the legislation of hate crime in Ireland. This research also has the potential to inform health care systems on how best to support these individuals following these traumatic experiences. Your participation will provide valuable feedback and broader environmental challenges people like you experience.
In order to do this I will be asking a series of questions. The interview will last between 45 minutes to an hour, but if you need a break or want to stop at any time, just inform the researcher. The interview will need to be audio-recorded for the purposes of transcribing your interview. All your data will be anonymised to ensure your confidentiality. If you have any issues with being recorded it may preclude your participation in this study; however, you are invited to discuss any issues you may have with the researcher.

The interview can take place in a location of your choosing. For example, if you are comfortable with inviting me to your home or another place you feel comfortable, I can arrange to meet you there.

This research study has received Ethics approval from the Education and Health Sciences Research Ethics Committee (pending approval number). If you have any concerns about this study and wish to contact someone independent you may contact:

Chairman Education and Health Sciences Research Ethics Committee
EHS Faculty Office
University of Limerick Tel

(061) 234101

Contact Details:

Supervisor: Dr Barry Coughlan
Department of Psychology
University of Limerick
Phone: 061-234345
Email: barry.coughlan@ul.ie

Dr Amanda Haynes
Department of Sociology
University of Limerick
Email: amanda.haynes@ul.ie

Researcher: Kristina Cahill
Email: 14042061@studentmail.ul.ie

Consent Form

If you would be willing to participate in this research study, please read and sign the statement below:

I _____ agree to participate in an interview for the purposes of investigating the lived experiences of trans people and the wider gender variant community with transphobic discrimination and/or hate crime, and their understanding of resilience following these experiences.

I understand the nature and purpose of the exercise. I have had an opportunity to ask questions and all of my questions have been answered at this time. I have been given sufficient time to consider my participation in this study.

I understand and have agreed that the interview will be recorded and understand that all information relating to my participation will be kept strictly confidential unless the researcher is concerned that I am at risk of harm to myself or others.

I understand that I may request a copy of any and all materials relating to the exercise at any time.

I understand that I may withdraw from the study at any point, for any reason, without any penalty.

This research study has received Ethics approval from the Education and Health Sciences Research Ethics Committee. If you have any concerns about this study and wish to contact someone independent you may contact:

Chairman Education and Health Sciences Research Ethics Committee
EHS Faculty Office
University of Limerick Tel
(061) 234101

Signed (Participant): _____
Signed (Researcher): _____

Date: _____

Appendix E: Debriefing form

Transgender Equality Network Ireland

UNIVERSITY of LIMERICK
OLLSCOIL LUIMNIGH

Thank you very much for taking part in the study. Your participation has been really valuable in providing an insight into experiences of transphobic discrimination and/or hate crime and resilience following these experiences. I understand that you may have questions in the hours and days after you leave this room. If you would like to meet again to have another chat about anything that you feel this has brought up please get in touch and I will arrange to meet you again.

If you have any queries about your personal contribution or data, or the project overall, please do not hesitate to contact me (14042061@studentmail.ul.ie), or my supervisors. Contact details are listed below. Data you provided will be held for a minimum of ten years in line with the Freedom of Information Act and Data Protection Act (2014).

If you have been distressed in any way by taking part in this study there are a number of resources available I can help you to avail of. I can refer you onwards to psychological services should you feel you would like additional support following the interview. I also have provided a list of support services from TENI below.

Thank you again for taking the time to participate.

Researcher: Kristina Cahill **Supervisor: Dr Barry Coughlan**

Email: 14042061@studentmail.ul.ie **Email: barry.coughlan@ul.ie**

NATIONAL

TENI (Transgender Equality Network Ireland)

National

T (01) 873 3575

E info@teni.ie

W www.teni.ie

The TENI website offers information on a range of support services that aim to increase the well-being of trans people and their families by providing support that mitigates common experiences of isolation, misunderstanding and exclusion.

NATIONAL

Crime Victims Helpline

National

T 116 006

E info@crimevictimshelpline.ie

Crime Victims Helpline offer support to all victims of crime in Ireland and are here to listen. They will give you time and space to talk about your experience.

NATIONAL

LGBT Helpline

National

T 1890 929 539

W www.lgbt.ie

The LGBT Helpline is a non-judgmental and confidential service providing listening, support and information to lesbian, gay, bisexual and transgender (LGBT) people, their family and friends, and to those who are questioning if they might be LGBT.

NATIONAL

The Garda Racial, Intercultural & Diversity Office (GRIDO)

National

T +353 1 6663150/3817

W www.garda.ie/Controller.aspx?Page=154

Staff members of the GRIDO coordinate, monitor and advise on all aspects of policing in the area of diversity. You will find a link to the Garda LGBT Liaison officers, who have been trained on LGBT related issues and will help you if you are having difficulty reporting a crime.

Appendix F: Ethical approval

From: "Anne.OBrien" <Anne.OBrien@ul.ie>
Date: Wednesday 8 June 2016 12:19
To: "barry.coughlan" <Barry.Coughlan@ul.ie>
Subject: RE: 2016_05_16_EHS

Dear Barry

Thank you for your amended Research Ethics application which was recently reviewed by the Education and Health Sciences Research Ethics Committee.
The recommendation of the Committee is outlined below:

Project Title: 2016_05_16_EHS Exploring resilience in transgender individuals who have experienced transphobic discrimination and hate crime
Principal Investigator: Barry Coughlan
Other Investigators: Amanda Haynes, Kristina Cahill.
Recommendation: Approved until August 2017.

Please note that as Principal Investigator of this project you are required to submit a Research Completion Report Form (attached) on completion of this research study.

Yours Sincerely

Anne O'Brien

Anne O'Brien
Administrator, Education & Health Sciences
Research Ethics Committee
Ollscoil Luimnigh / University of Limerick
Guthán / Phone +353 61 234101
Facs / Fax +353 61 202561
Ríomhphost / Email: anne.obrien@ul.ie
Gréasán / Web: http://www.ehs.ul.ie

Appendix G: Extracts from reflective memos

07/07/16

Just completed first interview with participant, process went well. I felt the participant was quite nervous so I felt keen to help manage her anxiety, before starting the interview. Not sure whether this was a crossover from my clinical role? Also I found it difficult not to reflect back constantly what the participant said to me. I'm not sure whether this was my own way of processing it or again, part of my clinical role. Must be aware of this in future interviews.

11/08/16

Interview started off with some uncertainty, participant reported feeling nervous about meeting me so asked whether she could bring along her partner for support. I was mindful of participant's wellbeing throughout the process as she discussed some quite traumatic experiences. Key phrases that come out of it for me are 'resilience through experience' and 'importance of external support'. Think we covered different aspects of coping as well. What was interesting was the potential for differences in this person's experiences of transphobic hostility compared to those previous participants. Reflection appeared possible in this one. Maybe I could have got more on the support part. Think it's in there though. I feel kind of energised by this interview. Felt there was a lot of good stuff in it.

11/01/17

Just developed initial codes, etc. from interview 1. Coping is definitely one that I think will be relevant. I'm not sure whether to call it coping or managing, as coping can sometimes be classified as adaptive and maladaptive. Must discuss with Amanda, as I think it's beyond the scope of the study for me to interpret whether a strategy is adaptive or not?
I'm also wondering how to break it down as it covers different types of coping: active, internal and externally seeking support and so on. The participant also talks about experiences of seeking external support and not seeking external support? I don't know whether these will have to be separate?
I also have an initial code of impact of resilience where the participant talks about their understanding of what resilience means to them. I'm not sure whether this will come under the coping theme more generally, but I'll keep myself open for the moment and see how the coding develops.

08/03/17

Just looking back over my initial mind-maps and seeing how my themes have evolved. The more I read them, the more I think I will have to leave the descriptions of hostility as a separate piece, rather than incorporating them as their own theme. The data is so rich that I could potentially spend the whole thesis talking about just 'coping' or 'resilience' so I need to go back and establish what are the most consistently visible themes.

Appendix H: Sample interview transcript with IPA coding

Experiences of discrimination - Impact of being misgendered, dismissal of identity Importance of/need for understanding Coping: avoidance/dissociation, expecting rejection Difficulties in familial relationship Coping: acceptance Importance of/need for understanding Experiences of discrimination - Impact of being misgendered, dismissal of identity	Well I don't feel great obviously, it doesn't upset me as much as it used to, I've come to understand that I just can't get to everyone and it's exhausting anyway, but I would prefer if they, I would feel a lot better if they at least tried to show, or be respectful. It means that I would minimise contact with them, I would only limit contact to, even some of my own family…they use no name around me, when I'm not there they refer to me by my old name, not all of them…but some of them. It just means well ok fine, they know that at this stage I am now legally (name) and I would prefer to be called (name), they don't have to call me (name) but if they don't then I will minimise contact with them because they know how I would prefer to be called…and if they don't well…I mean I've pleaded with them before it just, I minimise contact, I feel upset but funnily enough I have come to a greater acceptance of it, I just, the people worth having in my life will make the effort anyway. Like, I go to (café) in town with Mum a lot, because mum is old, I went through a difficult time there with some of the staff still referring to me as a man and I just kept on, I only persisted in going there because mum is old, there's no steps, we both know a lot of people there and actually we both would be friendly with a lot of people there, but if it wasn't for mum I wouldn't have continued going there, but	The impact of being not being identified by others as how they identify themselves - don't feel good, can be very upsetting, exhausting Is there something here about recognizing your own identity and the toll repeated dismissal of same identity has on the individual? Would feel much better if people attempted to be respectful Minimizing/limiting contact with people who do not identify her - a defense mechanism? Awareness even within own family relationship that she will minimise her contact with them Pleading with family to recognise, caused upset before, more accepting of it now - what does the acceptance give to the individual, is it resignation, a further protection from continued hurt? Understanding that the people worth having relationships with will be more respectful Routine of going to a particular café with mother, still referred to by male pronouns - if it wasn't for mother, participant would have stopped going The fear of causing a scene by drawing

Experiences of discrimination - fear of drawing attention to oneself	she's old and I get part carer's allowance for her…but it was difficult with staff there for a long time…because if you correct them, then you risk causing a scene and people hear, and you draw attention to yourself but it's not…its always appropriate to do so but you risk drawing more attention to yourself and that can make things worse…	attention and correcting staff - <u>the difficulty between realising what is right versus making a difficult scenario even worse</u>
	Ok, would you be able to tell me about your own personal experience or experiences of transphobic discrimination?	
Experiences of discrimination/hate crime: verbal abuse/harassment Feeling hostility from others, feeling threatened Reflecting on rationale for abuse - discrimination Feeling hostility from others, feeling threatened	Well the most major one was in (shopping centre), the head security man there, about seven or eight years ago he followed me around abusing me. Allegedly I was walking on a wet floor, there was a wet floor sign, but it was a busy Saturday afternoon, there was hundreds of people there…he followed me, he chose me, this is a big strong tough security man and he followed me, abusing me, threatening to bar me, screaming and roaring at me, loads of people saw, loads of other security men…why do you think he singled me out? There was loads of people there, hundreds of people, so when I went to complain him, he followed me into (shop) and said 'you're not going to be able to complain about me there's nobody to go to' and I contacted the centre manager and had a meeting with him, mum and dad. He grudgingly	Verbal abuse from security man at shopping centre / harassment Feeling singled out amongst lots of others, shouted at, following, being very threatening *Questioning why she had been singled out as opposed to everyone else* Doesn't believe the apology was meant, questions the man's rationale for abuse *Reiterating the point of being singled out - that she makes this point more than once*

Experiences of discrimination: Feeling personally victimized Experiences of discrimination: the trauma of experience Experiences of discrimination: lack of justice Experiences of discrimination: the trauma of experience Experiences of discrimination: lack of justice Coping: linking in support organisation	apologized, he said he shouldn't have done it because it was somebody with glasses, which was his apology, so it would have been right to abuse somebody if they weren't wearing glasses? Maybe if they hadn't seen the wet floor sign, but the point is he singled me out and there was still a look of rage on his face when he said 'well I shouldn't have told you off in inverted commas because you were wearing glasses, maybe you didn't see the sign'. So why did he single me out? Was it right to follow me around abusing me? A few years later I was stopped from using the female toilets there in (same shopping centre) by the girl who was manning the toilets, but I assume it was under instruction, so I sent a letter…I mean I was crying for hours, I mean I rang my mother, I was crying all day long and I regularly get flashbacks of that man screaming at me, following me around. I wake sometimes and it pops into my head…I go around and have a shower and it might pop into my head and worst of all he's still there…I sent letters, I even got my solicitor to send letters, I even tried to take him to a tribunal but there's a six month deadline and they didn't answer letters and before I knew it the six months had gone, you take out the Christmas month but they didn't answer letters, they deliberately ignored letters and by the time I went to the tribunal six months had past. But that was really really traumatic and what's more is he's still there, and he still works and is still in charge…he done that to me, and he's in charge...and	*indicates the impact she is placing on it* *Questioning why she was singled out, why was she abused* Stopped from using female bathrooms Feels personally victimized, assumes it's related to the previous incident, feels extremely upset, is a traumatic experience for participant, experiences regular flashbacks: post traumatic stress Flashbacks can often invade as part of her daily routine, during unrelated tasks *The worst part for her is he is still there* Lack of justice, has tried to pursue it legally, feels they deliberately ignored her letters *Emphasising the trauma of the whole scenario by repeating same phrase 'he's still there' questioning why he was able to do that and get away with it* Linked in with organisation for support *Questioning has this happened before?*

Not being able to move past the trauma	I see him all the time. So (community support service) had to get onto him, but he's still there and the new centre manager wants nothing to do with, know anything about it…what else has he done to other people he didn't like the look of?	
	What was he saying to you?	Gaining a context to verbal abuse
Significance of impact of traumatic event Experience of discrimination/hate crime: misgendering Seeking help Awareness of impact of trauma on the self Lack of justice Feeling ostracized/marginalized	He was screaming and roaring at me, and people were wondering what's going on? It's about seven or eight years ago now but it was around like 'I'll bar the fucking bastard…I'll get him barred…Where's he fucking going…'He was screaming and shouting expletives and he even followed me into (shop), when I went to find somebody to talk to, and I went to find a manager to talk to and he followed me up there…so it's not just that he's still there, but he's still in charge….it's a trauma and I don't think trauma is too strong a term, I mean it pops into my head all the time, worse because he's still there, I don't feel I ever got justice and it was all obstructed. If centre management had any standards, he'd have been long gone but they just didn't want to know…probably because they would have had to admit liability and plus they probably don't really care very much about people…it says a lot about the person…the fact that he's still there…	<u>Despite being 7/8 years ago participant can remember almost exactly what was said: the significance of the traumatic event</u> Misgendering, misuse of pronouns, screaming verbal abuse, following them into shops Trying to seek help from managers *Again reiterating 'he's still there but he's still in charge'* <u>Fully aware that the event was hugely traumatic for her</u> No justice, feeling that the pathway to getting justice was obstructed Feeling that they didn't care, didn't want to accept responsibility